



# YUVADERMA

## E-BULLETIN



May 2017, Vol. 1, Issue. 3



### THE ESSENCE

The artwork reflects the essence of Yuvaderma, where young minds are nurtured and moulded into the building blocks of tomorrow.

It represents the journey to the key of enlightenment and success via the road of knowledge, team work, dedication and perseverance.

PIONEERS IN  
DERMATOLOGY-II **6**

RED FLAG CUTANEOUS  
**13** SIGNS IN AN  
ICU SETTING

THE SCARS  
UNDERNEATH  
HER SCARS **19**



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## THE EDITORS NICHE

*"The greatest gifts you can give your children are the roots of responsibility and the wings of independence"*

As we turn one today, all our efforts and zeal in nurturing this seed of a thought and moulding it into an educative, informative & fun newsletter have been fruitful and effective. We started with the initiative of giving the residents of Karnataka an opportunity to display their academic as well as their extra-curricular streak, this kept us an edge apart from various other newsletters doing the round.

In this one year, Yuvaderma E-bulletin has grown as an endeavor reaching out to students all over Karnataka. We the editorial board have grown closer as a team and most importantly as friends. We have worked tirelessly and eagerly over months and days to bring to you this compendium with a hint of difference. So, here's wishing the E-bulletin a very Happy Birthday and may it soar like an eagle and reach heights never achieved before. A word of gratitude to the IADVL-KN state executive for giving us the roots of responsibility and the wings of independence to express ourselves and spread our expanse.

Our anniversary issue has a lot of special articles in store for our readers. The medley begins with the second edition of 'Pioneers in dermatology', a quick revision article especially for those historical viva questions. Giving you an insight into the life and likes of an inspiring leader is our next article with a fun rapid fire twist to it, inspire yourself with the journey of Dr. Ramesh Bhat in our interview segment. Futuristic is the authors take on introducing super specialization courses in the ever-expanding field of dermatology. Sharpening your clinical skills and bringing you face to face with the danger signs in an emergency setting is our next educative article, 'Red flag cutaneous signs in an ICU setting'.

Taking our readers through a walk down memory lane is our special section 'It's our Birthday!' followed by the artistic and fun strip of our very own original cartoon, 'The Derma-toon'. Sharing her soul touching experience is a young resident, who urges us to sometimes look beyond the obvious and empathize with our patients in 'The scars underneath her scars'. Dermaclinics from its collection brings to you a case report on Keratoacanthoma Centrifugum Marginatum. Exercising those dormant grey cells, next from our brain tickling segment is the Quiz! Beauty or beast in the bottle, is not an article based on the famous





fairy tale but is the authors effort in creating awareness about the dangers associated with the much-hyped fairness creams, in our Yuva-awareness segment.

After our delectable first installment of 'Food eponyms in investigative dermatology', we now present to you the very appetizing 'Food eponyms in clinical dermatology', a recipe to remember especially in the viva voce examination. Giving you the answers of the quiz is the answer key followed by our most important segment, the Feed back. We hope you like our medley of academic and extracurricular articles alike, do give us your feedback, contribute and become a part of the Yuvaderma family.

As I come to the end of another editorial, I hope we add more and more years of wisdom, efficiency, team work, academic excellence, talent, readers and more & more epic editions to our credit. We hope you have a good read and look forward to our next issue as much as we do.

Already working on it!

Signing off,



**Dr. Saloni Katoch**  
(Editor-in-Chief)



PIONEERS IN DERMATOLOGY - II

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**Dr. Vaishnavi Gopal**

IT'S OUR BIRTHDAY!

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DERMA-TOON

**Dr. Preethi B Nayak**

THE SCARS UNDERNEATH HER SCARS

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A variant of Keratoacanthoma

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QUIZ

**Dr. Dharam Gowda**

"BEAUTY OR BEAST IN THE BOTTLE"

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FOOD EPONYMS IN CLINICAL DERMATOLOGY

**Dr. Kirti Katwe**



## PRESIDENT'S PREAMBLE

**C**ongratulations to Dr. Saloni and her team 'Yuvaderma' for putting their best efforts and completing one successful year!! Success is another name for repeated, unflagging effort.

Publish and attain 'Scientific Nirvana' is the new 'mantra' of scientific excellence. KN –IADVL has given an opportunity to explore curricular and extra -curricular talent among our residents.

Youth means a temperamental predominance of courage over timidity, of appetite over the love of ease.

I am sure this issue will create more enthusiasm in all our residents, to come out with many better ideas for the next issue too!!!

Happy reading to all.

Warm regards,

**Dr. Arun C Inamadar**

President,  
IADVL Karnataka.



**FOREWORD**



## HON. GENERAL SECRETARY SPEAKS

**A**t the outset, I send my greetings to the Editorial Board of Yuvaderma, for working on a magazine best in all aspects. It has been a year since the inception of the Yuvaderm group, Dr. Saloni and her team have brought out 3 issues of the magazine which is very informative. The current issue has many novel articles like 'Food eponyms in Dermatology'. The article on our president elect will be very inspirational for all youngsters.

I hope future editions will add exam oriented topics along with research based articles. IADVL Karnataka is committed to assist our young members in actualizing their full potentials.

Long live IADVL.



*Shashikumar B. M.*

**Dr. Shashikumar B. M.**

Hon. General Secretary,

IADVL Karnataka.

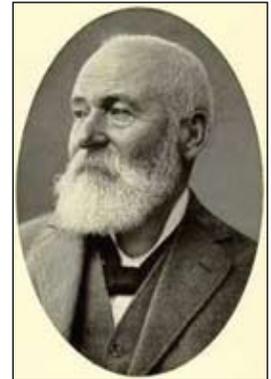
**FOREWORD**



## PIONEERS IN DERMATOLOGY - II

### PAUL GERSON UNNA (1850-1929)

- Paul Gerson Unna is well known almost only for the revolutionary Unna boot.
- Paul Unna was born in Hamburg and perceived his masters degree in Dermatology from Vienna.
- Under the tutorship of the anatomist Waldeyer, he presented the thesis "Contribution to Histology and Formation of the Dermis and its Annexes".
- He was the first to describe the Stratum granulosum
- In 1927 he described Unna's disease, a chronic disease of the skin with seborrhoea of the scalp and of the areas on the face and trunk that are rich in sebaceous follicles.
- He described the Unna-Thost disease, which is a non-epidermolytic palmoplantar keratoderma, comprising of a group of non-syndromic forms of diffuse keratoderma that histologically do not show cytolysis in the upper spinous or granular layers.
- Along with Voerner and Thost, he gave the description of Voerner-Unna-Thost disease characterized by palmoplantar keratoderma associated with epidermolytic changes on histology, due to mutations localized to a hotspot region of KRT9.
- The use of dithranol for the treatment of psoriasis was first explained by Unna in 1916.
- Enumerated Marie-Unna hypotrichosis types 4 and 5
- Described Intradermal nevi
- Unna boot : The Unna boot was created for the treatment of venous stasis ulcers and for some use in selected eczematous dermatoses during the 1880s. It was originally a cotton bandage impregnated with zinc oxide, gelatin and glycerin paste, which when applied in a semi-rigid state, confers compression along with the advantages of a moisture-retaining occlusive dressing. It should be changed once a week unless heavy drainage from the wound necessitates more frequent replacement. Correct application of the Unna boot prevents excessive or abnormal pressure to the limb, compromised circulation, skin breakdown, additional ulcer formation or further limb deterioration.
- He described the procedure of Comedone extraction.
- The Grenz zone, which is a band of normal-appearing dermis separating the epidermis from the underlying infiltrate is also referred to as Unna zone.
- Unna was the first to demonstrate that mast cells were responsible for the cutaneous eruption in patients of mastocytosis, and over 60 years later, Ellis reported the first patient with the systemic disease.
- Seborrheic dermatitis was described by Unna.
- Renault, Unna and Spalteholz suggested that a cone arrangement of the cutaneous microvasculature served as an explanation for the occurrence and pattern of livedo reticularis.



**Dr. Shweta P. Bhadbhade,**  
PG-3, Mandya Institute  
of Medical Sciences,  
Mandya.



## AN INSIGHT INTO THE LIFE & LIKES OF DR. RAMESH BHAT



**Pragmatic, energetic, outgoing, hardworking & knowledgeable; these five words are very minimal to describe the magnitude of the person who I am privileged to have an interview with today. Sir is an eminent teacher, researcher and former Head of department of Dermatology, Father Muller medical college, Mangalore. A Dr. LN Sinha memorial awardee; Prof. Ratan Singh national awardee along with multiple other awards and the National President elect of the Indian Association of Dermatologists, Venereologists and Leprologists (IADVL). Presenting to you the leader himself Dr. Ramesh Bhat.**

**Preethi Nayak (PN) :** Hello sir, firstly a small insight into your childhood, Where did you do your schooling from? How was it to be born to non-doctor parents and be able to achieve so much?

**Sir :** I studied in a Kannada medium school till 10th standard. I basically am from a village in Udupi named Marne, my initial schooling that is 1st and 2nd standard was at a place called Moodubelle. We then shifted to Basarikatte in Chikmagalur, a remote place where my father worked as a high school head master. My schooling from 3rd to 7th standard was in Sacred Heart primary school at Chikmagalur followed by high school from Sri Sadhguru high school. For pre-university, I came back to my hometown Udupi and joined MGM. Back then, we did not have any entrance exams, and on the basis of pre-university marks I got a MBBS seat in VIMS, Bellary. After that, I did DVD from KMC, Mangalore and MD from BMC, Bangalore. In my family, my elder brother is a doctor and he is 2 years senior to me.

**PN :** During your MBBS days which branch were you interested in? And what was the sheer force that pushed you towards taking up this branch?

**Sir :** My main interest was in General Medicine. As I did not get general medicine seat back then, my second option was allied branches like psychiatry or dermatology. I preferred dermatology over psychiatry.

**PN :** Any remarkable incident during your post-graduation that you will cherish throughout your life?

**Sir :** Hmmm... The days of my MD while I was in Bangalore were the initial days of formation of various city branches of Dermatology, like how we now have the Karavali dermatology society. Two senior dermatologists, Dr. Sathish DA and Dr. Srinivas Murthy, and of course with the help of Dr. Sacchidanand, started the Bangalore dermatology society. We were post graduates then and started presenting cases in various discussion forums. That was the beginning of the city chapters in Karnataka! So, in those days we learnt that interaction with our fellow colleagues is an important requirement in expanding our knowledge.

**PN :** What qualities will make a resident an ideal dermatologist?

**Sir :** Firstly, sound and basic knowledge of dermatology. Presently, the problem is that everyone is concentrating only on cosmetology. Actually, basic dermatology and its knowledge is a must to be a good cosmetologist or dermatosurgeon. Selection of cases for dermatosurgery or the type of procedure which has to be done in



cosmetology is best done with this knowledge. Secondly, good clinical exposure, nothing is lost by seeing more patients. Infact, each patient is like a book of dermatology. Hence both theoretical and practical knowledge, along with a sense of patient care is required to be an ideal dermatologist.

**PN : Sir, Dermatology is a very volatile branch, what advice would you give residents regarding the study pattern, study hours and the books to read? All the residents reading this interview will definitely have this question at the back of their minds.**

**Sir :** Read more, that is the key!! So, if we read repeatedly then the subject will not be volatile, it becomes solid! \*winks\*

And about study hours, depends on an individual's ability to grasp the concept. During residency all standard books must be read.

**PN : Any guiding force in your life that has made you the achiever you are today?**

**Sir :** Whatever I am today is due to the hard work that I have put in. But if I have to quote someone in my life, then it has to be "Dr. Sacchidanand", we can consider him as our mentor. It is not just me; but many dermatologists in Karnataka consider him as their mentor. In fact, when I was doing my post-graduation, he was a lecturer in BMC. He used to encourage us a lot to publish papers, present papers at conferences, to attend conferences and various workshops. Unlike others, he used to nurture our new ideas and used to push us ahead, so that something new could be achieved.

**PN : Your experience with the organisation of innumerable academic programs, workshops and conferences, that you have been the commander in chief for.**

**Sir :** No! Not commander in chief! I am also a worker only. All conferences and CME's that have been conducted is with the help of all our colleagues, it has been a team effort. So, it is very important that when you ask someone to do something, you should also put in your hard work and take everybody into confidence. Then, a successful programme or event will automatically follow.

**PN : Sir, how do you balance being an academician, consultant and an administrator?**

**Sir :** Work once taken up requires complete concentration and attention. We also have to see that we achieve something in whatever we do, be it academic work, patient care or any administrator duties.

**PN : Your thoughts on being one of the very few recipients of the Dr. L N Sinha Memorial award, National Young Dermatologist award and the Prof Ratan Singh award.**

**Sir :** There are many people who have received these awards, I am not the only one! I feel it is just one of the many ways of recognizing someone's work. It is the recognition bestowed on you by your fellow colleagues and seniors in the field for the services that one has rendered.

**PN : How does it feel to be the 2nd dermatologist from Mangalore to be elected for the esteemed post of 'The President of IADVL'**

**Sir :** Actually, I should thank all the dermatologists of our country and the members of our association for having faith in me and electing me to this post. It is due to the work that I have done as the state secretary and also the national secretary.

During that period, whatever services we render to our members, play an important role in the election of the IADVL President. And of course, I will try to do some more good work during my tenure as the IADVL President.

**PN : Sir what are the rungs of the ladder to be the president of the IADVL?**

**Sir :** See, it is not possible to jump for this post. You will have to walk slowly. What we have done, most of us, whoever has been elected as the President, in our association is that we have started from our city branch or from our state branch. If you



work honestly then automatically success will follow. It is basically the hard work that counts a lot.

**PN : Sir, would you like to reveal any new ventures that you plan under your tenure as the president.**

**Sir :** \*Smiles\* Firstly, we are planning to have our own building in Delhi. So, I would like to at least initiate the process during my term as the president.

Secondly, nowadays, you see many people (from other branches) are trying to practice dermatology. Many youngsters feel that our branch is being encroached upon by other specialties. So, for that we want to try and initiate a legal cell. This is in the pipeline.

The third thing is that we want to have a good rapport with the government and the Medical Council of India so that there will be some rationalization of various processes.

**PN : Your opinion regarding doctors from other branches, beauty parlours or even quacks encroaching upon our specialty and eventually causing harm to the patients.**

**Sir :** The most important action for this is to educate our community and also our patients. We need to inform people and spread awareness that we are the actual skin care doctors and we work on a scientific basis. We have to educate the public regarding this.

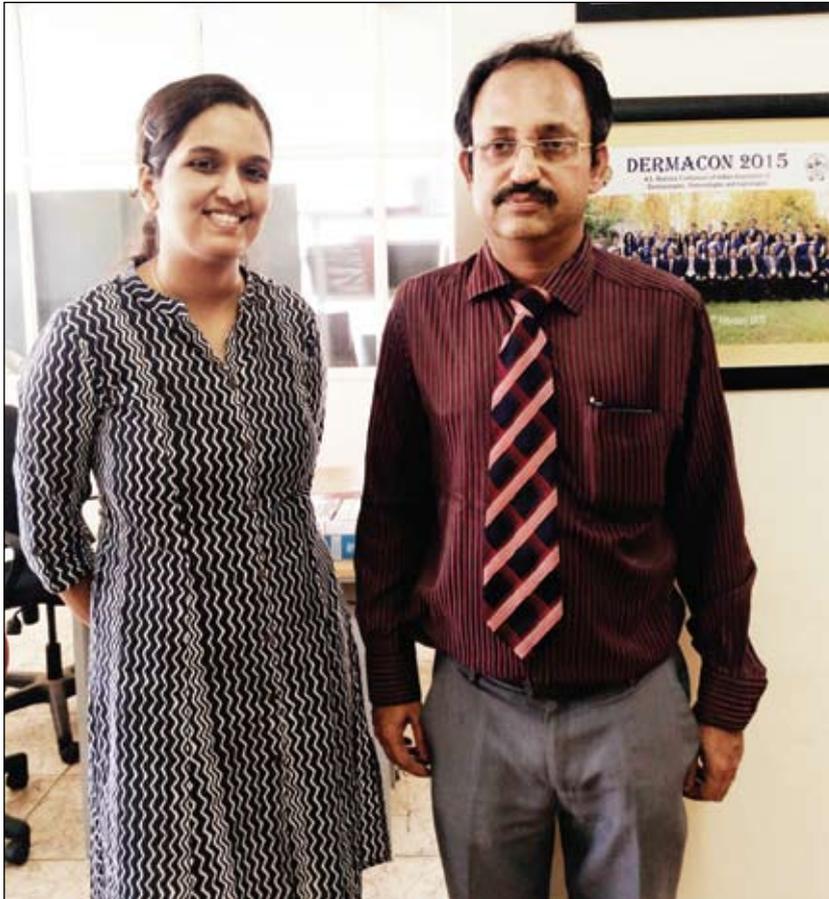
Secondly, in case somebody is doing some harm, we have to identify them and inform the concerned authority. For example, there are a few agencies that train individuals in different specialties of medicine including dermatology. They, then misleadingly practice as dermatologists or skin specialists. We have to fight against this and we will do so now!

**PN : Sir, you have been in an institute which has an attached leprosy hospital and have been serving in it for almost 3 decades now. What is our role as dermatologists against this disease and the stigma attached to it?**

**Sir :** As of now the incidence has come down, but we still do get a number of cases. So, the most important thing is that all dermatologists should be able to recognize leprosy. The moment you miss the diagnosis of leprosy, the problem arises. The stigma is mainly due to the deformity. Deformities can be prevented by early diagnosis and proper management of the disease, management of the reaction and early recognition of any complication. All dermatologists should be thorough as far as diagnosing leprosy is concerned and it is our commitment to the society to recognize the disease at the earliest and treat it adequately. Nowadays, rate of leprosy as such has come down, but still; we do see it among children and also so many infective cases of leprosy are still prevalent. The proportion of deformities as such has come down but we still have patients who develop claw hand, foot drop etc. So, it is our responsibility to prevent it and educate the public regarding it. I think we are already quite successful in this venture due to which we don't have such a big stigma as far as leprosy is concerned. In fact, it is vitiligo which is in limelight now, and we have a major role to play. We have to spread awareness that vitiligo is just an autoimmune disease and it is not contagious contrary to the popular belief.

**PN : In your practice, has there ever been a moment when a dermatological condition in a patient has touched you emotionally?**

**Sir :** Many a times it has happened especially when we treat difficult cases such as toxic epidermal necrolysis, pemphigus etc. For an instance, when I was a student, there was a patient who developed TEN. She was almost on her death bed. I along with our fellow colleagues would personally do the dressings because the nursing staff used to be quite scared to treat the patient. The patient was a very young girl and she improved. After I completed my MD degree, I settled here, and even now for any minor skin ailments she comes here, all the way from Bangalore. This is one of the cases that I still remember. There are many like that, those who are from Mumbai or working in the Gulf



countries still come to us for minor skin ailments as we have treated them with concern and passion and not just as mere patients.

**PN : Sir, any advice to residents who want to pursue fellowships abroad? What should be their mode of approach?**

**Sir :** See, through our association we have some financial support for fellowships in dermatopathology. This is the one which we have initiated. Presently, we are encouraging youngsters to attend various conferences abroad. It may be EADV, International congress of Dermatology, WCOCD to get some good exposure. Within India there are many fellowships, they are called observerships, through our senior IADVL members, who are doing well in their practice. It may be dermatopathology or dermatosurgery or may be cosmetology, in all these fields we are providing observerships. If somebody wants to do it abroad then they have to pursue it themselves. In some of the countries we are not allowed to touch the patients because even though we are qualified dermatologists, we might not have the legal sanction to treat the patient there. So, we can just do observerships in many of these institutions abroad. Presently, dermatopathology fellowships are best provided in the USA and China. Those who want to pursue

fellowships in cosmetology, can either go to Singapore or any other European country. As for dermatosurgery, I feel the best place is India because the amount of vitiligo surgeries that are being done here is probably the highest in the world. In fact, we are now planning to share our expertise with other countries as well. For example, one of our doctors has gone to Egypt recently to share his knowledge.

**PN : How can we expand our horizon as dermatologists and what should be our fields of focus in the future?**

**Sir :** Dermatology is a very broad subject. In future, we may have exclusive pediatric dermatology or dermatopathology or people exclusively practicing cosmetology, dermatosurgery or lasers, that is the future. The area where the focus should be depends on the interest of each individual. For example, someone interested in dermatosurgery may not be interested in the pathology of dermatological diseases but everyone must have basic dermatological knowledge to be successful in these fields. Presently, we have few doctors like Dr. Deepak Parikh who exclusively practice paediatric dermatology. Similarly, we have so many people who exclusively practice dermatosurgery. So it basically depends on personal interests.



**PN :** Sir, there are so many budding dermatologists like me who aspire to be like you some day. Any words of wisdom for us?

**Sir :** First thing is hardwork and the second is honesty. If these two qualities are there, you will achieve and automatically succeed in life.

**PN :** Sir, we have introduced a new segment this time, the RAPID FIRE, so let us keep it rapid?

**Sir :** Yes definitely!

1. **Favourite book in dermatology**  
Rooks textbook of dermatology
2. **Favourite cuisine/dish**  
Pickles \* chuckles \*
3. **Favourite movie**  
Movieeeee... Hum aapke hain koun!
4. **Favourite pastime when you are at home**  
Spending time with children and also doing some gardening.
5. **Best conference**  
Of course! It has to be Dermacon 2015!
6. **How is it being the HOD?**  
Nothing much, it is just an additional job.
7. **Dream for the future?**  
IADVL should be the pioneer in the field of dermatology all across the world!
8. **One word to describe dermatology?**  
Not one word, I would say dermatology is a combination of art and science. Practising dermatology is art and science.
9. **Most inspired by (any 2 colleagues)? We already know one, the others would be?**  
Yes, I would like to mention three names here; Dr.Sacchidanand, Dr. Ganesh Pai and Dr. JN Shetty.
10. **Are you a tea / coffee person?**  
I am a coffee person \* giggles\*
11. **If you were given the power to change anything, like Modi government or anything... what would it be?**  
\*giggles\* Oh yes! Fight against corruption.
12. **Anything in your life that you would want to rewrite?**  
I wanted to settle down in Bangalore immediately after my post-graduation. So, if I have to rewrite something then it would be settling down there.
13. **I never get tired of -----?**  
Sleeping \* laughs\*

#### 14. Your ideal day?

An ideal day is one where there is good work and at the end of the day there is satisfaction with the work done.

#### 15. If I gave you a plane ticket to anywhere in the world where would you go?

Europe! I have been there multiple times and I like that place, especially Switzerland.

#### 16. What have you always wanted to do, but have never done?

I wanted to be the Prime minister of the country \*laughs\*

#### 17. Favorite topic in dermatology?

Dermatology in medicine.

#### 18. Lasers/ biopsy/ peel/ fillers/ electro-surgery/ derma-abrasion. Kindly arrange this in an order of your liking. First being the most liked.

Biopsy > peel > electro-surgery > lasers > derma-abrasion > fillers

#### 19. FIVE favourite questions as an examiner?

Dariers epidermal nest, Do you know what it is?

**PN :** Hmmm ???

- Etymology of Tacrolimus
- Immune area of Wade
- Brick and mortar theory
- Biologics

**PN :** I would like to pass on a message to all the residents reading this interview. Sir has told me the answers to his favourite questions, and this is your chance now to gain some extra marks by looking up for these answers ;):D

So, this is Dr. Ramesh Bhat, the National president elect of the Indian Association of Dermatologists, Venereologists and Leprologists (IADVL), currently residing and practicing at Mangalore giving you readers an honest and informative insight into his admirable and inspiring life. Thank you for this wonderful opportunity sir.



**Dr. Preethi B Nayak,**  
PG-2, K.S. Hegde Medical  
Academy, Mangalore.



# **FUTURISTIC : SUPER SPECIALIZATIONS IN DERMATOLOGY**

**S**uper speciality courses play an important role in the present era in achieving quality medical care, better treatment outcomes and improvement in the quality of life of patients. These courses in other branches have enriched the field of medicine. Their success has paved way for addition of newer super speciality courses across various other branches of medicine. Dermatology also has the potential to flourish if super speciality courses are introduced in the near future.

The mindset of patients today is such that when spending out of their pockets, they are not just looking for a medical professional who holds a MBBS or a MD degree but they opt for doctors with the highest degree in that particular field. A patient will have more confidence and faith when he or she is being treated by a doctor with specific training and expertise in that particular field.

With increasing research, development of new scientific methodologies and technology in the medical field, there is an overwhelming amount of data in each speciality. In this scenario, a medical professional without super specialisation becomes the jack of all trades and master of none. Super specialists will

have an expertise in the concerned sub-field, which results in highly specialised care for the patients.

Dermatology is in its nascent stage, evolving day by day. New information, theories, ideas and technology are coming into the domain. With changes in lifestyle, environment and food habits, new patterns of dermatological conditions are emerging. Introducing super speciality courses in the field of dermatology can equip dermatologists with the required knowledge and experience to tackle these newer emerging conditions.

With increasing demand for various dermatological procedures, it makes sense to super specialise in order to gain experience in that particular sub-field. For example, a dermatologist who has keen interest in dermatopathology can choose this field for super specialisation and can excel and diagnose dermatological conditions better than a regular pathologist as he or she will have thorough clinical knowledge which can then be correlated with the histopathological features for accurate diagnosis and treatment.

Dermatologists may have keen interest in different sub fields. Introducing super speciality courses will help them gain an in-depth knowledge and will encourage them to practice in the domain of their choice. In areas like paediatric dermatology or occupational dermatology where conditions look very similar and are difficult to manage, introducing super specialist courses will result in an accurate diagnosis and treatment. In this manner, reference can be given to a particular dermatologist specialised in that particular field. This will bring about a reformation in the field of dermatology, resulting in better satisfaction for both patients and their doctors.

A practicing super specialist offers the advantage of housing the best clinical talent on one hand and the best technology on the other. Investment in high end technology becomes economically feasible in

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**DERMATOSURGERY**

**Paediatric Dermatology**

**Dermatopathology**



## RED FLAG CUTANEOUS SIGNS IN AN ICU SETTING

As budding dermatologists, we are trained to look out for clinical cutaneous signs that serve as wonderful aids in the diagnosis of a vast majority of conditions. We must also train ourselves to identify “danger signs” manifesting in the skin, be it a worsening of dermatologic process or a systemic condition. Here I have compiled some of the bad prognostic signs and danger signals, in an Intensive Care Unit setting, that should set our brain alarms off, if we are ever to encounter them.

- 1) **Janeway lesions** are non-tender haemorrhagic macules over finger tips. Seen typically in the setting of bacterial endocarditis. It has also been described in certain other conditions like systemic lupus erythematosus, haemolytic anaemia, gonococemia, typhoid and staphylococcal septicaemia.

Do's- Look for splinter haemorrhages and Osler's nodes. A cardiology reference, conventional / transoesophageal echocardiogram, blood culture and sensitivity can be sought.

Don't- Neglect systemic examination findings.



Janeway lesions (Courtesy of DVL, Yenepoya Medical College)



Dengue exanthem (Courtesy of DVL, Yenepoya Medical College)

- 2) **White islands in a sea of red** - A generalised confluent erythema with rounded islands of sparing, typical of second phase of dengue exanthem occurring 3-6 days after the onset of fever. The initial rash is a transient facial flushing erythema and appears in the first 24-48 hours of onset of symptoms.

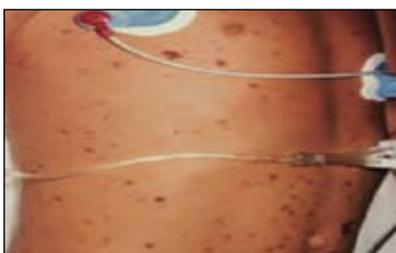
Do's- Look for petechiae, purpura, ecchymosis and positive tourniquet test which are features of dengue hemorrhagic fever and dengue shock syndrome.

Don't- Label as a mere viral exanthema, treat on an outpatient basis.

- 3) **Symmetric Progressive Gangrene (SPG)** is asymmetrical distal ischaemic damage at two or more sites in the absence of large-vessel obstruction. It is an ominous prognostic sign of disseminated intravascular coagulation. This in the setting of fever, pallor, cyanosis, painful cold extremities and restriction of joint mobility; should always raise suspicion of SPG. The organisms implicated are pneumococcus, staphylococcus and streptococcus.



Symmetric Progressive Gangrene (Courtesy of DVL, Yenepoya Medical College)



Meningococcal hemorrhagic rash

- 4) **Hemorrhagic rash of meningococcal meningitis** - This cutaneous feature is a hallmark of invasive disease and is seen with a background of high fever, nausea, arthralgia and diarrhoea. Early cutaneous features include a transient maculopapular rash.

Do's- CSF gram stain and culture.

Don't- Delay in initiation of parenteral antibiotics



- 5) **Haemorrhagic vesicles** in varicella are an indication of severe immunodeficiency. Fatal systemic complications like encephalitis and pneumonia can ensue in this setting.  
Do's- Tzanck smear, serological tests for HIV. Prompt parenteral antiviral therapy.



Haemorrhagic vesicles in varicella (Courtesy of DVL, Yenepoya Medical College)



Ecthyma gangrenosum (Courtesy of DVL, Yenepoya Medical College)

- 6) **Ecthyma gangrenosum** is a cutaneous manifestation of invasive *Pseudomonas aeruginosa* infection in immunocompromised and critically ill patients. It is characterised by a well defined gangrenous ulcer with back- grey eschar and surrounding erythema/necrosis. Shock and renal failure are frequently seen in these patients.  
Do's'- Sepsis screen, swab culture, coagulation profile, limb Doppler.

- 7) **Eschar of Scrub typhus** is the most characteristic feature signifying site of attachment of the larval mite. It appears as a black necrotic cigarette burn like lesion. Patients present with fever, respiratory distress, significant thrombocytopenia, jaundice, renal failure, encephalopathy and multiorgan failure syndrome.  
Do's- Careful diligent search for lesions when suspected.



Eschar of Scrub typhus (Courtesy of DVL, Yenepoya Medical College)



Purpura fulminans (Courtesy of DVL, Yenepoya Medical College)

- 8) **Purpura fulminans** is a life threatening condition characterised by tissue necrosis, small vessel thrombosis and disseminated intravascular coagulation. It is categorised into acute infectious (most common), neonatal and idiopathic.  
Do's- Coagulation profile, blood culture and sensitivity, D- dimer levels

- 9) **Nicolau syndrome** is an unforeseeable but potentially serious complication following intra muscular injection of a variety of drugs. It is characterised by severe pain followed by pallor and livedoid haemorrhagic erythema at the injection site. It can sometimes lead to cutaneous, subcutaneous and even muscular aseptic necrosis with ulceration.  
Do's- Doppler and MRI of limb to delineate the extent of damage



Nicolau syndrome (Courtesy of DVL, Yenepoya Medical College)



Congenital systemic candidiasis  
(Source: Internet)

**10) Burn like dermatitis** in an infant with congenital systemic candidiasis, affects very low birth weight babies. Infections are acquired in utero or postnatally. Oral thrush, apnoea, bradycardia, hypotension, abdominal distension, hyperglycemia, temperature imbalance, leukemoid reaction and guaiac positive stools are other features.

**11) Blueberry muffin spots** seen in congenital rubella, cytomegalovirus, toxoplasmosis and herpes infection of the newborn. They occur as a result of extramedullary haematopoiesis. It usually develops within 48 hours of birth and neonates can remain otherwise asymptomatic. They appear as non-blanching blue red macules and dome shaped papules favouring the trunk and head. 5% neonates develop sequelae of the infection in later infancy, the most common being sensorineural hearing loss.

Do's- Viral culture of urine and saliva, skin biopsy to rule out vascular and neoplastic conditions  
Don't- Label as anevroid condition



Blueberry muffin spots  
(Atlas of Dermatology )

## 12) Drug related

- a. Methotrexate toxicity- Sudden development of oral ulcers and cutaneous erosions.
- b. Dapsone- Blue discoloration of fingertips reflecting cyanosis. If neglected patients can go into shock.

These are a few of the danger signs that my department staff and I have come across but the list goes on. I conclude by quoting a simple yet powerful excerpt by Louis A Duhring-

“The power of making a correct diagnosis is the key to all success in the treatment of skin disease; without this faculty, the physician can never be a thorough dermatologist, and therapeutics at once cease to hold their proper position, and become empirical.”

- Louis A Duhring, MD, 1845–1913, American physician and professor of dermatology.



**Dr. Vaishnavi Gopal,**  
PG-3, Yenepoya Medical College,  
Mangalore.





As we turn one today, we remember the year gone by with some of our editors sharing their experience about their onboard journey with the Yuvaderma. We hope this initiative has many more years added to its fun & educative self.



*'With nervous hands I pressed send, little did I know that I will work beyond my ken, I sit down on my chair to pen it all, waves of memories run through my soul.'*

I still remember the day when I was given a chance to be a part of the first, one of a kind, resident's magazine Yuvaderma E-bulletin. Soon a WhatsApp group was formed and we were assigned duties.

Then began the journey, journey beyond words, one of the best days of my residency. Thoughts beyond imagination, days of tireless work and the fun of doing the same, is what the past year has been to me. From what has to be done to how to get it done, from showing us new paths to nurturing our new ideas, from helping us out with the topics for exams to being a senior whom we can look up to anytime, Dr. Saloni mam has always been there like a guiding star.

Along with this the constant support and guidance of my HOD sir Dr. Girisha B S, also Dr. Tonita Noronha & Dr. Akshata Alva who have fuelled me with ideas and have been there through the thick and thin of this journey. At the end of one year I would say this E-bulletin along with all my five co-editors and Saloni mam will always be very close to my heart and these moments of working together for this newsletter will be cherished throughout my life. Thank you for letting me be a part of Yuvaderma.

**- Dr. Preethi B Nayak**



Here we are at the third issue, and what an incredible experience it has been. How fast one year flew by, which I think is because this year of mine has been greatly productive. Our team lead by Dr. Saloni Katoch, who never failed to inspire us to be extra creative, think out of the box and is so warm and open to all kinds of ideas. We as a team have definitely grown over the 3 issues. This has been a wonderful experience for me in a personal way too as in addition to my love for dermatology I could alongside open doors to creativity. Thank you IADVL Karnataka for this great opportunity.

**- Dr. Vaishnavi Gopal**





This is a rare platform which a budding dermatologist can get to express his or her views on various aspects of modern dermatology. A platform where we interact with each other, take suggestions and work towards one goal. I had a lovely working experience and am eager to contribute more. Thanks to the editor for giving me this opportunity.

- Dr. Manoj Srinivasa

I am glad that Yuvaderma has completed one year successfully. I feel honoured for being given the opportunity to work as one of the co-editors of this newsletter. It has been a great learning experience. I had the chance to



interact with some inspiring people and work alongside a great team. Looking forward to many more interesting rendezvous. I hope Yuvaderma continues its contribution to dermatology for many years to come.



- Dr. Dharam Gowda



“Don’t just count your years, make your years count”

As we turn one today, I remember the day I received a call from Dr. Shashikumar sir, giving me the opportunity of creating a newsletter that catered to the residents & young dermatologists alike. I remember the six enthusiastic residents who volunteered to be a part of this novel endeavor and there has been no looking back ever since. The newsletter that you read is a product of months and days of collecting articles, editing, more editing, designing and redesigning.

We have grown from a seed into a plant and hope to spread our expanse to reach residents in every nook and corner of Karnataka. I would like to thank Shwetha, Vaishnavi, Preethi, Kirti, Dharam and Manoj for their endless ideas, enthusiasm and zeal. A word of gratitude to the IADVL Karnataka state executive and all our teachers for empowering their residents with forums like these to express themselves. Mr. Shridhar works behind the scenes but no newsletter is complete without his layout and design, we thank you for your contribution. Last but not the least, God almighty for blessing the newsletter with an accepting and wonderful response, my parents who have always encouraged me in all my ventures and have borne with me and my glaring laptop for the last one year.



For all those who love writing, academic or extra-curricular, are most welcome to be a part of the Yuvaderma family. You can write to us on [iadvlkn.ebulletin@gmail.com](mailto:iadvlkn.ebulletin@gmail.com). We hope to add on more and more years of good work, wisdom and quality to this one year infant of ours.

- Dr. Saloni Katoch, Editor-in-chief



## THE DERMA-TOON



Concept by :  
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## FUTURISTIC : SUPER SPECIALIZATIONS IN DERMATOLOGY

... from page 12

this case as the specialist doctor requires minimal equipment which is used on a large number of patients.

The prime objective of any medical practitioner is to provide the best possible medical care to the patients and this can be achieved by vigorous training in focussed speciality courses. An accurate diagnosis combined with the latest treatment options will result in better outcomes and patient satisfaction.

A medical professional armed with super specialisation also gains focussed experience. This makes it easier for them to research in their chosen field and explore newer treatment modalities.

Keeping all the above said points in view, we can say that introducing super specialisation in the field of dermatology will be beneficial not only for the patients and doctors, but it will also enrich our profession.



**Dr. Dharam Gowda**  
PG-2, Rajarajeshwari  
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## SOUL SEARCHING

# THE SCARS UNDERNEATH HER SCARS

*“Never be ashamed of a scar. It simply means you were stronger than whatever tried to hurt you.”*

- Unknown

International Women’s Day 2017 was a regular day for me. Regular until I met a young woman who woke me up to its true significance. As a dermatology resident, I was going about my regular activities for the day. One of the patients on my list happened to be one with facial scars, scheduled for an injection of platelet-rich plasma. She seemed a bit anxious at first. So, I reassured her and talked to her about the procedure after which she calmed down. I started the procedure for the multiple scars she had across her cheeks and forehead. Being a painful procedure, I noticed a tear streaming down her cheek after a few injections. So, I decided to stop and talk to her for a while.

“How did you get these scars?” I asked her, quite casually as I normally would. She wiped the tear from her cheek, looked me in the eye and without any emotion said, “My husband did it.” Behind my surgical mask, I sucked in a breath. I froze, I did not know what to say or do. What can you say in such a situation? I looked at her scars again, the

deep linear scratches and somehow, they looked different now. More brute, more painful.

I have read so many terrifying incidents of abuse towards women, most of them more horrifying than this. Yet, this incident struck a chord with me. Perhaps it was because she was right in front of me. The fact that a man could hurt a woman the way a predator hunts its prey is appalling.

As dermatologists, we see scars day in and day out. We try so many different techniques to make them less visible. From lasers to excisions, we try our best to make it look like the scar was never there. We take pictures before and after to demonstrate how effectively we have erased their very existence.

Now as I look back at the picture I took before the procedure, it pains me to know that there is so much horror within. It is not just an image of the scars, but there is so much more underneath. Try as we may to make the surface look relatively normal, what about the scars that are branded on her soul? Those will stay with her forever.

What I wanted to say to her was that I was proud of her, for owning her scars. She didn’t lie or hide the truth to protect the man that assaulted her. Coming forward and being honest is what most women in this country are terrified of doing.

As residents we tend to get lost in a world of cases, books and seminars. But sometimes we just need to slow down and pay attention to the world beyond medicine. There is so much more than what meets the eye. This kind of assault does not limit itself to any one stratum of the society. This was me doing my part in spreading awareness about the menace that is plaguing our society.



**Dr. Michelle Vishu,**  
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## Keratoacanthoma Centrifugum Marginatum : A variant of Keratoacanthoma

**K**eratoacanthoma Centrifugum Marginatum (KCM) is a rare variant of Keratoacanthoma (KA) and is characterized by multiple keratoacanthomas with progressive peripheral growth and simultaneous central healing. KCM was first described by Miedzinski and Kozakiewicz in 1962 and the name was coined by Belisario in 1965.<sup>1</sup> The cause of multiple keratoacanthomas is unknown. Heredity, viruses, chemicals, and sunlight are thought to be involved in the etiology of KCM.<sup>2</sup>

### Case Report

A 47 year old male from rural Sullia, presented with complaints of multiple asymptomatic, non-regressive, firm, dome shaped nodules with central keratotic core of varying sizes. It initially started over the trunk and later progressed to involve other sites like arms, neck and genitalia for a duration of six years. Since the last one and a half years there was no change in the size of the lesions. No history suggestive of any other systemic involvement was present. The patient did not have any family history of similar lesions. He had not been administered any drugs and there was no history of exposure to any chemicals.

On cutaneous examination,

multiple asymptomatic, non-regressive, firm, dome shaped nodules with central keratotic core of varying sizes, the smallest one being 0.5 x 0.5 cm and the largest one measuring up to 8 x 7cm were present predominately over the trunk, arms, neck and genitalia (figure 1,2 and 3).

A biopsy was taken from the upper chest and sent for histopathological examination. It showed epidermal hyperplasia (pseudoeplitheliomatous hyperplasia) with central crater-like hyperkeratosis. The keratinocytes had enlarged nuclei with glassy cytoplasm without hyperchromatism or atypia. The dermis was infiltrated with mononuclear inflammatory cells (figure 4 and 5). Laboratory examinations, including complete blood count, renal and liver function tests were normal. KCM was diagnosed on the basis of the patient's characteristic clinical and pathological presentation.

### Discussion

Keratoacanthoma is a rapidly evolving tumour of the skin, composed of keratinizing squamous cells originating in pilosebaceous follicles and resolving spontaneously if left untreated. KA has recently been reclassified as a well-differentiated SCC (keratoacanthomatous type) in the World Health Organization (WHO) and RCPATH UK classifications.<sup>3</sup> KA is a common skin tumour characterized by a dome-shaped nodule with a central crater-like keratin plug.<sup>4</sup> This lesion is usually solitary and tends to resolve spontaneously. KCM is a rare variant of KA that





Fig.4

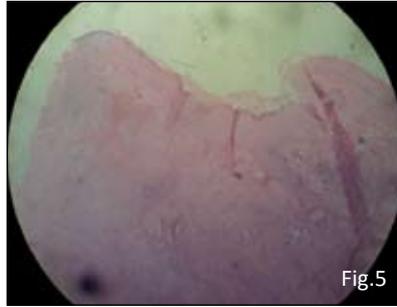


Fig.5

is characterized by progressive peripheral growth.

The lesions are variable in size, ranging from 2 to 40 cm in diameter and they frequently involve the extremities, face, neck, and rarely, the trunk. KCM usually does not undergo spontaneous remission. According to reported cases, most authors have described no tendency for spontaneous resolution in KCM. Spontaneous resolution can occur, but more cases progress continuously for years. Some

have been associated with considerable tissue destruction.<sup>4</sup> Therefore, some authors believe that this tumour actually is a low-grade squamous cell carcinoma and some recurrence but not metastases has been described.

As a result, active treatment was suggested for almost all reported cases. However, therapy for KCM can be challenging. Numerous effective treatments have been described, including surgical excision, Mohs micrographic surgery, topical and intralesional

5-fluorouracil, topical imiquimod cream, oral etretinate, oral and intralesional methotrexate, oral retinoids, intralesional bleomycin, local radiotherapy, photodynamic therapy, and systemic erlotinib. No consensus regarding treatment regimens have been established.

### Conclusion

KCM is an uncommon variant of KA. Multiple modalities exist for the treatment of keratoacanthoma. Excisional surgery is the treatment of choice for majority of keratoacanthomas. This can result in functional and cosmetic defects when large or strategically located lesions are treated. An effective nonsurgical treatment would be desirable in such cases. Intralesional therapy, with methotrexate can be used as an alternative treatment for KCM.<sup>5</sup>

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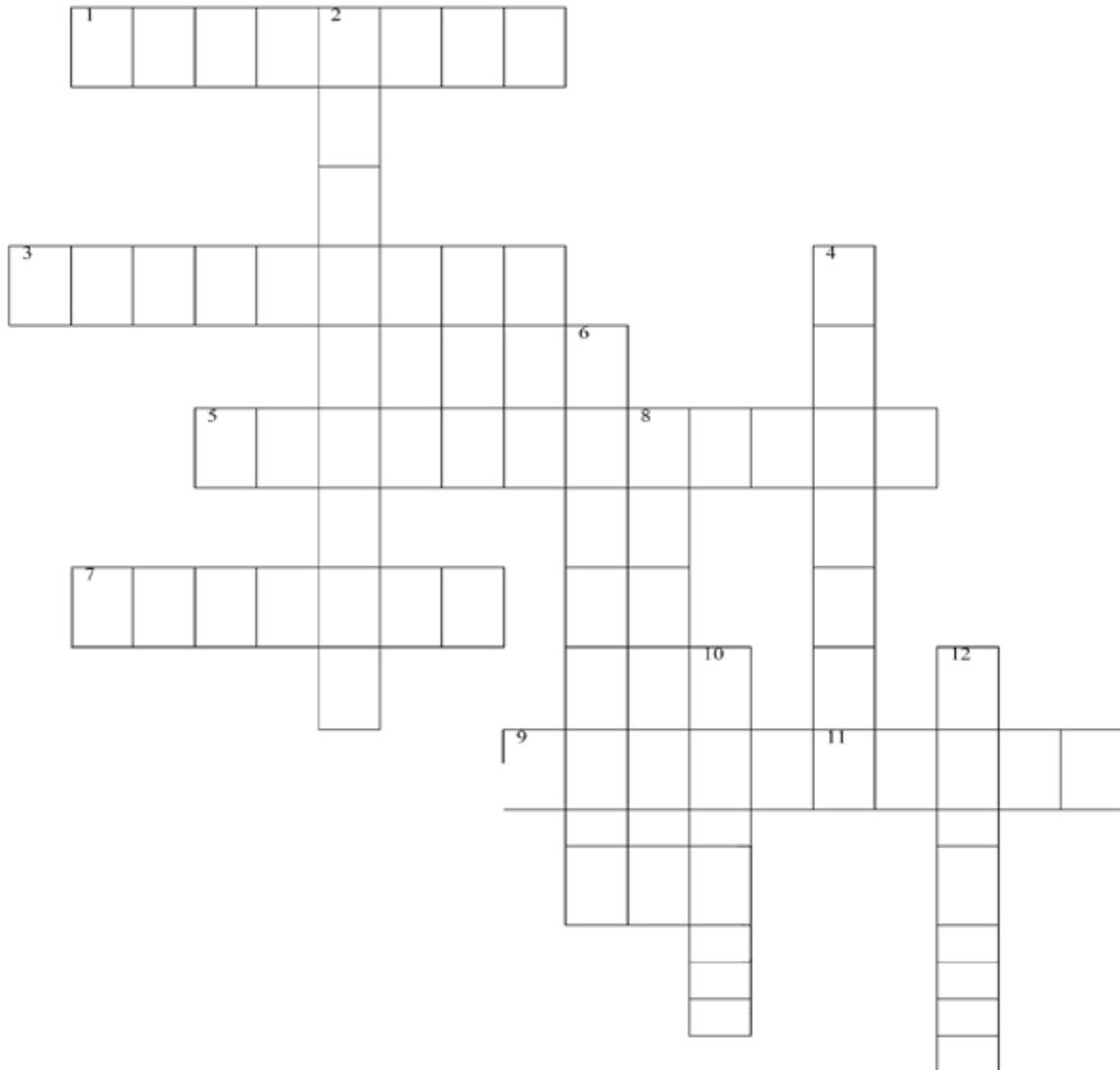
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ACROSS

DOWN



1. \_\_\_\_\_ score is used to quantify joint laxity & hypermobility (8)



3. \_\_\_\_\_ test is used for clinical evaluation of patients with Marfan's syndrome(9)



5. \_\_\_\_\_ spots are seen as an enanthem in Rubella (12)



7. The image represents \_\_\_\_\_ sign (7)



9. \_\_\_\_\_'s sign or the diagonal ear lobe crease is seen in the image below (5)



11. The image represents \_\_\_\_\_ sign seen in Dermatomyositis (5)

2. Vertically oriented split of hair shafts with proteinaceous material and erythrocytes present in the split usually seen in trichotillomania gives rise to \_\_\_\_\_ sign (9)

4. Rubbing a lesion of mastocytoma causes urtication, flare, swelling and sometimes blister formation due to release of histamine. This is known as \_\_\_\_\_ sign (7)

6. Name the sign described in Fordyce disease which with prominent lip involvement can result in a lipstick like mark left on the rim of a glass mug after consuming a hot beverage (8)

8. Inability to retract the lower eye-lid in patients of progressive systemic sclerosis gives rise to \_\_\_\_\_ sign (7)

10. \_\_\_\_\_ sign is seen in keratosis pilaris where individual follicles show a long strand of keratin glistening when examined in tangentially incident light (7)

12. \_\_\_\_\_ sign in patients with delusions of parasitosis is characterized by the patient collecting skin debris with a mistaken belief that such collected material contains an alleged insect or parasite (8)



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## “BEAUTY OR BEAST IN THE BOTTLE”

*- An eye opener about the adverse effects of fairness creams*

have many ingredients and one must have an accurate knowledge of these. This article aims at providing information about the ingredients in these fairness products.

The various ingredients in fairness products are as follows.

**1. Hydroquinone :** Hydroquinone also known as dihydroxybenzene, is a hydroxyphenolic compound that is structurally similar to precursors of melanin.<sup>[1]</sup> This is one of the most effective lightening compounds known, however, concentrations used and individual skin responses vary. Adverse reactions commonly encountered are irritation, which is the most common complication. Others include erythema, stinging, irritant and allergic contact dermatitis, nail discoloration, transient hypochromia, paradoxical postinflammatory hypermelanosis and ‘confetti-like’ depigmentation which is characterized by mottled depigmented spots on the macules of melasma. Exogenous ochronosis, a blue-black pigmentation of the treated areas, is mainly reported in darker skin from prolonged use of strong concentrations but can also be seen in whites with use of 2% Hydroquinone preparations.<sup>[2]</sup>

The best way to use hydroquinone for pigmentary disorders is under the guidance of a dermatologist, in appropriate concentrations along with other compounds that will neutralise its side effects

**2. Kojic Acid :** It is a naturally occurring, hydrophilic fungal product. It acts by inhibiting free tyrosinase, has antioxidant properties and can cause side effects like irritation and erythema.<sup>[3]</sup>

**3. Retinoic Acid :** It is a vitamin A derivative that works by peeling off the upper layers of the skin. Retinoids affect multiple steps in the melanization pathway.<sup>[1]</sup> Most common side effects are erythema, burning, stinging, dryness, scaling and hyperpigmentation in dark individuals.<sup>[4]</sup>

**4. Azelaic Acid :** It is a naturally occurring, saturated, 9 carbon dicarboxylic acid that inhibits tyrosinase and induces direct cytotoxic

“No matter what skin colour you are on the outside, it’s all about what you are like on the inside”- Norman sykes, a well-known saying but hardly has any impact on our society.

Fair skin is considered as one of the must haves for all ladies who wish to look beautiful. In a country where marital profiles and job perspectives are determined by one’s skin colour, an obsession with fairness creams is understandable. The fascination with fairness creams is not new but the last decade however, has seen a stream line of fairness products hitting the market with most Indians falling prey to these multimillion cosmetic industries.

An average Indian is obsessed with fair complexion. It’s quite unfortunate to see people ruining their smooth and healthy skin by using a variety of cosmetics, every possible cream and face pack to obtain a fairer complexion. Fairness products





effect on melanocytes. Adverse effects include erythema, burning and pruritus.<sup>[5]</sup>

**5. Glycolic acid :** Glycolic acid is an alpha hydroxy acid, usually combined with other agents in a concentration of 5-10% for its skin lightening properties. It probably acts by epidermal remodelling and also by inhibiting tyrosinase.<sup>[6]</sup> The most common adverse effect is irritation.

**6. Ascorbic acid :** It has antioxidant properties and affects melanogenesis by reducing dopaquinone to DOPA.

**7. Plant extracts :** These range from the use of fruit or flower extracts or essence to arbutin, liquorice and bear berries as they are known to possess skin lightening properties,<sup>[7]</sup> but studies have shown that these products are not as effective as hyped by the cosmetic industries.

According to a study by a Delhi based NGO, apart from the above-mentioned ingredients fairness creams can also contain mercury, chromium, lead, nickel and copper that may cause various adverse effects. Apart from the common side effects like itching, burning and erythema some products may produce irritant contact dermatitis and photosensitivity.<sup>[7]</sup> Some products may also contain topical steroids which can lead to devastating side effects when used long term and without supervision of a doctor. Thus, before using any over the counter fairness products, consultation with a dermatologist is mandatory as they will offer an expert opinion on the type and form of product that has to be used depending on the individual's skin type and condition.

Thus, if you do have healthy skin, appreciate it and do not get misled by these fairness campaigns. Every product has its own merits



and demerits, thus in the process of lightening one's skin colour, one may lose its natural quality.

Even though, the white rulers have left our country decades ago, India still continues to be a slave to these skin related misconceptions. From fair-complexioned film stars to a very high and needless demand in the market of the skin-lightening creams, the notion really never went away. We as dermatologists must propagate how true beauty comes from within and not from one's skin colour and must counsel patients appropriately.

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# FOOD EPONYMS IN CLINICAL DERMATOLOGY



**'Vision is the art of seeing what is invisible to others'**

Dermatology is a visual speciality, some appearances being compared to fruits, vegetables and other food products making it easy for one to remember. Our previous issue dealt with food eponyms in investigative dermatology, we now present to you food eponyms in clinical dermatology. We hope you savour this delicious academic compilation!

## FOOD EPONYMS IN CLINICAL DERMATOLOGY :

1. **Apple jelly nodules** : Granulomas of lupus vulgaris seen on diascopy. The nodules may also be seen in granulomatous lesion of leishmaniasis and sarcoidosis.
- b. **Blueberry muffin baby** : Neonatal purpura of congenital rubella syndrome.
- c. **Blueberry muffin lesions** : Seen in congenital cytomegalovirus infection as a result of primary infection during the first and second trimesters of pregnancy. The lesions represent erythropoietic tissue in the dermis derived from undifferentiated dermal mesenchyme. Infant presents with red to purple papules and nodules lasting for 4-6 weeks.



2. **Bean syndrome** : It is also known as Blue rubber-bleb nevus syndrome. Blue/purple, soft, dome shaped, nipple like rubber blebs, compressible nodules with a rubbery feel are seen.



### 3. The Berry collection :

- a. **Black berry stomatitis** : Seen in Paracoccidioidomycosis, primarily affects the mucous membranes of the mouth and is accompanied by marked adenopathy and granulomatous lesions that bleed easily giving an appearance of "black berry".

4. **Cafe-au-lait macules (French for "coffee with milk")** : Sharply defined, light brown patches that vary in size from 0.5 cm to 50 cm. They are present in a variety of genodermatoses such as neurofibromatosis type 1, McCune Albright syndrome, Leopard syndrome, Cowden syndrome and Silver Russel syndrome.





5. **Breakfast, lunch and dinner sign** : Clustered linear flea bite reactions.



6. **Cauliflower appearance** :

- a. **Genital wart, or Condyloma acuminata** - Causative organism is Human Papillomavirus, associated with sexual transmission and classically presents as a fleshy pink-coloured growth resembling a cauliflower.
- b. **Cauliflower-like growth** - Seen in verrucous carcinoma, a well-differentiated invasive squamous cell carcinoma.
- c. **Cauliflower ear (wrestler's ear)** - Secondary to trauma or continuous friction or chronic perichondritis.

7. **Caviar-like appearance** : (Caviar is a product made from salt-cured fish-eggs) : It is a feature of exogenous ochronosis. Pin-point hyperpigmented papules are noted after long-term application of hydroquinone.



8. **Cayenne pepper spots** : Irregular plaques of orange or brown pigmentation due to hemosiderin appearing within and at the edges of old lesions. Seen in progressive pigmented purpuric dermatosis (Schamberg's disease)



9. **Champagne bottle leg**: Progressive subcutaneous fibrosis following chronic lipodermatosclerosis giving the leg an inverted bottle shape.



10. **Cherry angiomas** : The most common vascular anomalies, characterized by ruby red slightly elevated round papules.



11. **Chicken skin appearance** : Pebbly surfaced skin seen in pseudoxanthoma elasticum.



12. **Corn flake sign**: Keratotic papules (2-3 mm) with discrete irregular polygonal margins. Seen in Kyrle's and Flegel's disease.

13. **Corn flake like crusts**: Seen in Pemphigus foliaceus.

14. **Curry-Hall syndrome** : Dental abnormalities associated with short limbs, polydactyly and nail dysplasia.

15. **Curry Jones syndrome** : Asymmetrical facial appearance, craniosynostosis, pre-axial polysyndactyly, agenesis of the corpus callosum and unusual skin with streaky areas of atrophy.

16. **Doughnut sign** : Central depression surrounded by an elevated rim of skin seen on the extended proximal interphalangeal joint in scleromyxedema.





**17. Fish mouth appearance (also called purse string appearance) :** Extraoral manifestations of systemic sclerosis include thinned out lips and microstomia along with perioral radiating furrows (rhagades) giving a “fish mouth or purse string” appearance to the oral aperture.

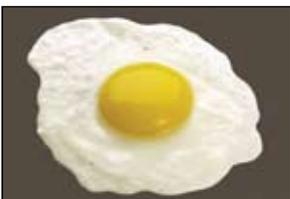


**18. Fish mouth wounds :** Gaping wounds produced in patients with Ehler-Danlos syndrome on minor trauma.

**19. Fish like scales :** Greek word ichthys means fish, seen in ichthyosis.



**20. Fried egg appearance:** Dysplastic nevus (atypical nevus) is typically a macular lesion that is 5 mm or more in diameter, usually with irregular, fuzzy borders. Sometimes, the lesions have a central papule surrounded by a macular pigmented rim creating a “fried-egg” appearance.



**21. Garlic clove fibroma**

: Also known as acquired periungual fibrokeratoma or acquired digital fibrokeratoma. Benign asymptomatic fibromas with a hyperkeratotic tip and a narrow base arising in the periunguim, especially at the proximal matrix.



**22. GEMSS syndrome:** It is an autosomal dominant condition with features of Glaucoma, lens Ectopia, Microspherophakia, joint Stiffness and Stocky short “pseudoathletic build.”

**23. Grain itch / Barley itch / Straw itch / Mattress itch / Prairie itch/Cotton weed dermatitis :** Itch caused by mites chiefly affecting the harvesters of wheat, hay, barley, oats and cereals or farm hands and packers who have contact with straw. Characterized by an urticarial papule with a vesicle.

**24. Honey comb atrophy :** Another name for vermiculate atrophoderma. It is a characteristic reticulate or “honeycomb” atrophy that develop as a late reaction to inflammation around horny follicular plugs on the cheeks.



**25. Lemon on matchstick appearance :** Seen in Cushing’s disease or Cushing’s syndrome, the most striking feature is central obesity with buffalo hump, moon facies, and protuberant abdominal wall and thin extremities, producing an appearance of ‘a lemon on a match stick’.

**26. Mango dermatitis :** Dermatitis in individuals exposed to Toxicodendrons species.

**27. Mulberry like erosions :** Granulomatous ulcers on mucous membranes in patients with Paracoccidioidomycosis.

**28. Mulberry molars :** Affected first molar has occlusive flat surface with only poorly enamelled rudiments of the usual cusps. A syphilitic stigmata.





**29. Nutmeg grater appearance :** The lesions in Pityriasis rubra pilaris (PRP) showing reddish-brown, roughly pinhead-sized papules topped by a central horny plug give a nutmeg grater appearance.



**30. Oil acne :** Acneiform eruption in the areas of skin that are in contact with oils and crude tars.

**31. Oil granuloma:** A granulomatous reaction to the injection of a relatively bulky oil fluid into the tissues.

**32. Oil spot :** It is seen in nails of patients with psoriasis.



**33. Peau d' orange :** Dermal oedema manifests as Peau d' orange appearance due to expansion of interfollicular dermis. It is seen in various conditions such as rosacea, pretibial myxedema, mastocytoma, and carcinoma en cuirasse.



**34. Port wine stain :** Macular telangiectasia, which is present at birth and remains throughout the life. Synonymous for nevus flammeus.



**35. Raspberry - like appearance :** Framboesia (framboesia in French means raspberry) is another name for yaws, a non-venereal spirochaetal infection affecting children caused by *Treponema pertenue*. It is characterized by raspberry-like excrescences.

**36. Salt and pepper pigmentation :** It is one of the earliest cutaneous findings in systemic sclerosis. It is characterized by the presence of patchy hypopigmentation and hyperpigmentation of the skin manifesting as vitiligo-like depigmentation with perifollicular pigmentary retention. The rich capillary network surrounding the hair follicle preserves melanogenesis thus retaining perifollicular pigmentation.

Salt and pepper appearance may also be seen as a feature of quadrichrome vitiligo.



**37. Sago grain like appearance :** A feature of dyshidrotic eczema (pompholyx) affecting the hands, fingers and sometimes the feet.

**38. Sausage finger :** Association of asymmetric oligoarticular arthritis of psoriasis with tenosynovitis results in sausage finger.

**39. Strawberry appearances:**

**Strawberry cervix - Trichomoniasis**



**Strawberry gums - Wegener's granulomatosis**





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Regards,  
**Editorial Team**