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INDIAN ASSOCIATION OF DERMATOLOGISTS VENEREOLOGISTS & LEPROLOGISTS

YUVA DERMA E-BULLETIN

YUVA

VOLUME : 9, ISSUE : 1
April 2024

YUVADERMA
E-Bulletin

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April 2024, Vol. 9, Issue 1

EDITOR'S CORNER

"Writing is an exploration.
You start from nothing and learn as you go."

- E.L. Doctorow

Dear Readers,

Welcome to the latest issue of Yuvaderma, where we delve into the insights and creative aspect of young budding dermatologist and postgraduate students. Our goal at Yuvaderma is to provide a platform to encourage the creative aspects of young dermatologists with informative and engaging content. In this issue, we have curated a diverse range of articles that cover various aspects of dermatology.

At Yuvaderma, we encourage and empower students and young budding dermatologists to share their dermatological research and ideas to continue their creative and academic interests. We hope that this issue inspires you to take proactive steps towards achieving your creative, academical and research career.

I would like to thank Dr. Mitaxari M Hugar, Dr. Mahesh and Dr Sujala Aradhya for giving me this opportunity to head the editorial team. I wholeheartedly thank my team for their efforts in bringing this edition to its conclusion. I thank Dr Priyanka and Dr Gagana for guiding me through this journey. I also thank all the residents who sent their articles and made this edition a success.

This issue starts with article that gives an insight into life and likes of Dr Mitaxari, the first woman president of IADVL Karnataka. It is a must read for all the residents. We also have covered

the topic on "Social media presence" in Dermatology. We have some engaging riddles and mnemonics, interesting case reports submitted by our residents. This publication emphasizes the importance of nails in Dermatology, particularly through a selection of articles dedicated to nail disorders.

Among the residents, there are also incredible artists and poets who were delighted to exhibit their talents.

As always, we welcome your feedback and suggestions for future topics. Thank you for your continued support, and we look forward to accompanying you on your journey to healthier, happier skin.

Warm regards,
Dr Chinmai C Chikkalagi
Editor-in-Chief
Yuvaderma

TREASURY

DR MITAXARI M HUGAR
PRESIDENT

PRESIDENT'S PREAMBLE

My dear residents and colleagues,

As the President of IADVL Karnataka, it brings me immense joy to address you through this message.

Your passion for dermatology and dedication to advancing the field are truly inspiring.

The YUVADERMA E-bulletin stands as a testament to our collective commitment to sharing knowledge and fostering growth within our community. From its inception in 2016 under the guidance of the late Dr. Umashankar, it has grown to become a cornerstone of dermatological education, not only in Karnataka but throughout India.

As we embark on the 18th edition of the Yuva-derma E-bulletin, I am confident that it will continue to uphold its reputation as a beacon of scientific excellence. May it serve as a catalyst for academic growth, their inner talent and inspire more young dermatologists to contribute their expertise to our ever-evolving field.

I encourage you to make the most of this publication, leveraging it as a tool for learning, collaboration, and professional development. Together, let us continue to push the boundaries of dermatological science and make meaningful contributions to patient care.

On behalf of IADVL KN I acknowledge your hard work and thank Dr Chinmai C Chikkalagi and her team Wishing you all the best in your endeavours.

Long live IADVL -KN
Warm regards,
Dr Mitaxari M Hugar (Kulkarni)
President
IADVL Karnataka

DR MAHESH KUMAR C
HON. SECRETARY

FROM THE SECRETARY'S DESK

Dear Young and Dynamic Colleagues,

It brings me immense joy and pride to extend my heartfelt greetings to all the young life members of IADVL Karnataka who are driving the future of dermatology with passion, innovation, and dedication. As the Honorary Secretary of IADVL Karnataka, I am deeply inspired by the energy and enthusiasm that each of you brings to our field. Your unwavering commitment to excellence and your relentless pursuit of knowledge are the cornerstones upon which the future of dermatology is being built.

The Yuvaderma Bulletin serves as a platform for us to celebrate your achievements, share your insights, and foster a sense of camaraderie among our young dermatologists. Within these pages, you will find a wealth of knowledge, practical guidance, and inspirational stories that reflect the diverse experiences and expertise of our members.

I am profoundly grateful to all the contributors who have generously shared their expertise and perspectives, thereby enriching this publication and contributing to the collective growth of our community. Your voices are instrumental in shaping the future direction of dermatology.

As young leaders in dermatology, you are not only the torchbearers of our profession but also the architects of its evolution. I urge each of you to seize every opportunity for learning, collaboration, and professional development, as you continue to push the boundaries of innovation and excellence.

Together, let us strive to create a supportive and inclusive environment where every young dermatologist feels empowered to realize their full potential and make a meaningful impact on the health and well-being of our patients and communities.

With warm regards
Dr. Mahesh Kumar C
Honorary Secretary General
IADVL Karnataka

DR. PRIYANKA KARAGAIAH
ADVISOR

ADVISOR SPEAKS

The world of dermatology as we know has undergone tremendous changes in the last decade. Not only have we progressed in understanding the diseases better but there's also been a revolution in the treatment available, especially in the field of aesthetics and procedural dermatology. From a bird's eye view approach, the focus is slowly shifting towards a holistic approach including lifestyle changes and routine skin care. Keeping this in mind, we bring to you the 18th edition of Yuvaderma e-bulletin with a fresh entree of topics, not just limited to the subject but also related to current practices and trends.

Keeping the non-academic interests alive while pursuing their academic endeavors is essential for a fulfilling life. We at Yuvaderma encourage non-academic articles, poems and art to keep this fire alive in an otherwise mundane life. Our non-academic section has poems, write-ups along with a few art pieces and photographs.

I wholeheartedly thank the team for their efforts in bringing this edition to its conclusion. I also thank all the residents who sent their articles and made this edition a success.

Dr. Priyanka Karagaiah
Advisors
Yuvaderma E-Bulletin

DR GAGANA B. GOPAL
ADVISOR

ADVISOR SPEAKS

"Alone we can do so little, together we can do so much"

- Helen Keller

It's been an honour to work with this amazing team of brilliant and talented residents from all over Karnataka. I heartily congratulate Editor in chief Dr Chinmai and assistant editors Dr Ruta, Dr Jinisha Jain, Dr Nimitha, Dr Pallavi and Dr Anushree for putting together this masterpiece.

Yuvaderma ebulletin, has always provided a platform for all the budding dermatologists to showcase their talents. This edition begins with the conversation with our first ever lady president of IADVL Dr Mitaxari ma'am. We can also find case reports on some rare and atypical cases which our residents came across in their residency. In this edition, we have focused on some interesting articles on nails, like our classic subungal fibromas, nail changes in lichen planus and a great insight on intralesional nail therapy.

I think we can all agree that dermatology is a very volatile subject so we do have few articles where the residents have come up with mnemonics to help us remember things. Another amazing piece I found was on the social media presence of us dermatologist which is booming in the market. And not to forget the remarkable sketches, photographs, riddles and poems we have received from the residents all over. Kudos to all the residents who have contributed to this ebulletin. It feels gratifying to see your literature and artistic skills.

I hope you all have a good read and enjoy.

Thanks, and regards

Dr. Gagana B. Gopal
Advisors
Yuvaderma E-Bulletin

A WOMAN WITH A VISION

Who turned dreams into reality!

Conversation with our first lady IADVL Karnataka President

Namaste ma'am, It takes great pleasure to get to know our first IADVL KN lady president a little more. Thank you for taking time out of your busy schedule for this conversation.

1) First thing first, how does it feel to be a first-ever IADVL KN lady president, ma'am?

Ma'am : It is an honor to serve as the President of the prestigious IADVL Karnataka association. It gives me immense pride, a sense of accomplishment, and purpose in advancing the field and supporting my fellow dermatologists. It is both rewarding and challenging, with immense pressure to perform well and meet the expectations of fellow dermatologists, especially considering the significance of being the first woman in such a powerful position. Holding such a high-profile position entails intense scrutiny, criticism, and challenges. Overall, I would describe it as a deeply rewarding yet demanding experience, and I consider it a significant achievement. Looking to the future, I am confident that many more women will rise to this position.

2) Could you walk us down a memory lane of your childhood ma'am?

Ma'am : As the daughter of an Indian Forest Service (IFS) officer, I had the privilege of moving frequently and experiencing life in various towns. I went to government schools, where I spent countless hours playing outdoors, exploring the woods with friends, and chasing butterflies in the meadows. These carefree days instilled in me a profound appreciation for the beauty of nature and ignited my curiosity about science and biology. My childhood was brimming with simple joys and unforgettable moments that have significantly influenced the person I am today.

3) How is life different today compared to when you were a child, ma'am?

Ma'am : Life today is very much different when compared to our times. I grew up in a small town nested in the countryside surrounded by lush greenery and the soothing sound of nature. During my days, personal relationships had more importance and the only source of entertainment was Television, where we used to watch Mahabharat and the landline was the only mode of communication. Now communicating with others who are miles

apart is a piece of cake through the invention of smartphones, which help us to remain well connected.

4) Did you always dream of becoming a doctor ma'am?

Maam : Yes I did. I vividly recall a school trip to KIMS (Karnataka Institute Of Medical Sciences) Hubli when I was in 3rd standard. I was mesmerized by the sight of young doctors with their aprons and stethoscopes, which left a lasting impression on me. My sister, who is an ophthalmologist, played a significant role in influencing my dream of becoming a doctor.

5) Did you join Dermatology residency by choice or by chance ma'am? Could you tell us more about your residency life?

Ma'am : Becoming a dermatologist wasn't initially my choice. I aspired to become a surgeon, inspired by figures like Dr. Ramesh Babu during my MBBS days. However, fate intervened when I encountered Dr. Hanumanthappa, who taught dermatology during our MBBS years. Despite my initial preference, I ended up securing a dermatology seat and continued along that path.

I pursued my post-graduation at KIMS Hubli, where my residency life became a golden era for me. I cherished every moment with my classmates, who were also my friends, as well as the undergraduate students at KIMS. Our teachers, particularly Dr. Tophakhane, were not only exceptional in teaching dermatology but also instilled in us the values of ethics and discipline.

6) Do you have any role model or someone you look up to?

Ma'am: My Father served as my role model in every aspect of life. I aspired to emulate his work ethic, sincerity, honesty, and dedication to

serving the community.

7) What is that one topic you are amazed at and showed a little extra interest in the dermatology branch, ma'am?

Ma'am : I started my career with my basic Dermatology practice but as I attended the conferences, I was amazed to see lasers and surgical works. I became passionate about it and learned about it by attending workshops. Then I had an opportunity to do it in the government medical college and developed the skills on my own. Soon, interest of mine became Dermatosurgery and lasers.

8) What are the hardships faced by you after completing your dermatology residency and finally settling in one place and how long did it take to do so ma'am?

Ma'am : In those days, as a woman, marriage was always considered of paramount importance. Consequently, my parents didn't allow me to start my practice at that time. My husband is an engineer employed in a software company, which led us to travel to many big cities and abroad. However, I seized this opportunity to learn advanced techniques in anti-aging treatments. Fortunately, his hometown is near Hubli, so we returned there and I began

my practice and also joined a government medical college. I was the first to establish a laser center in North Karnataka, pioneering an evolving branch of Dermatology. I maintained a strong rapport with senior dermatologists who regularly referred patients to me throughout the region. This facilitated the establishment and ongoing success of the center. Contributing to a community I am passionate about has been immensely fulfilling.

9) What is that one thing you did to stand out from the rest of your colleagues to mark a place where you are right now ma'am?

Ma'am : One significant factor that set me apart from my colleagues and contributed to where I am today is my unwavering commitment to continuous learning and self-improvement. Throughout my career, I have consistently sought out opportunities to expand my knowledge, refine my skills, and stay updated with the latest advancements in dermatology. Whether it was attending conferences, participating in workshops, or pursuing additional certifications, I have always strived to push myself beyond the status quo. This dedication to personal and professional growth has not only enabled me to excel in my field but has also helped me to make meaningful contributions to the dermatology community.

10) Apart from managing the responsibility of IADVL president of Karnataka, you are someone's Daughter, Wife, and Mother. Our readers want to know the secret behind managing both personal and professional life ma'am.

Ma'am : Initially I had a lot of difficulty to manage with my profession as a married woman. I had to effectively manage the home, utilize resources, take care of the child and do family assistance but my mother, brothers and sisters were very supportive of me and even my husband was very supportive and we tried to balance things. My child, Lipi is an amazing girl, never troubled me and I am blessed. Due to responsibilities of family, my duration of practice was decreased but the number of dermatologists was also less during our time so it did not affect my career much.

11) We would like to know your ideology and the changes we can expect from your tenure as an IADVL KN president ma'am.

Ma'am : Being the first female president would signify progress toward gender equality and diversity within the profession. It also involves a considerable amount of responsibility as a president would be tasked to lead the association, represent its members, and address various challenges faced by the Dermatology community. I aim to address prevalent issues like quackery faced by our young dermatologists. My approach involves raising public awareness to distinguish genuine dermatologists through lectures in

schools and colleges, targeting the future changemakers of our community, supported by initiatives such as ARIVU. Additionally, I plan to initiate legal actions against quacks gradually, ensuring accountability and safeguarding the integrity of dermatological practice.

12) You are a great source of inspiration to all the women like us. What advice would you like to give the young generation ma'am?

Ma'am : Let our young dermatologists not forget to learn the basics in the subjects first and not have a casual approach towards it, then learn procedures and lasers in the second innings of their course. Sincerity is a very important factor, communication skills are equally important nowadays to learn to become a good human being and not to forget professionalism.

13) This is a rapid-fire round ma'am. We would like to know the first thing that comes to your mind as soon as the questions are answered.

- **Your comfort food**
  Ma'am : Jawar Roti and Green grams
- **Your secret recipe**
  Ma'am : Obbattu
- **Your favorite actor/ actress**
  Ma'am : Amitabh Bachchan & Rekha
- **Movie close to your heart**
  Ma'am : Hum Apke Hai Kon
- **Things you cannot live without**
  Ma'am : Ambitions & my Daughter
- **Your weakness**
  Ma'am : My Daughter
- **Your strength**
  Ma'am : My Father
- **Stress buster**
  Ma'am : Yoga
- **Hobbies**
  Ma'am : Playing Carrom & reading novels
- **People affectionately call you by/**
  Ma'am : Mita
- **Mantra for healthier skin**
  Ma'am : Stress-free life
- **One thing you are afraid of**
  Ma'am : Lizards
- **One thing you enjoy doing**
  Ma'am : Driving a car
- **Your idea of holidaying**
  Ma'am : Going to the beach and relaxing
- **Best day of your life**
  Ma'am : When I joined MBBS
- **Your favourite dermatology textbook**
  Ma'am : Andrews Diseases Of The Skin: Clinical Dermatology
- **Your favourite non-dermatology book**
  Ma'am : Hombisilu by Usha Navarathna Raam
- **A thing you always wanted to do but couldn't**
  Ma'am : To become a Neurosurgeon
- **One vivid memory of yours**
  Ma'am : Trip with my students
- Post presidency, what next?
  Ma'am : To serve my community in a bigger way, of course through my profession!

DR. NIRMITHA S KUMAR
KIMS, Hubballi

NAILING IT : A Guide to Intralesional Nail Therapy

INTRODUCTION : The nail unit has an intricate anatomy. At its core lies the germinative matrix, with nail plate and the proximal nail fold guarding it above. The nail bedcontributes to both the formation and appearance of the nail plate.

Various dermatoses affecting nail unit are:

- Psoriasis
- Lichen planus
- Onychomycosis
- Subungual warts
- Trachyonychia
- Nail unit tumors.

Nail unit disorders impair cosmesis and diminish patients' quality of life and functional abilities. However, treating them proves challenging due to the limited bioavailability of drugs in the nail matrix and bed. Adverse effects due to prolonged systemic therapy and potential drug interactions may further deter its use, particularly in cases of predominant or isolated nail involvement. The slow nail growth exacerbates the burden of nail diseases, often resulting in inadequate treatment. Intralesional therapy offers a solution to these challenges.

Intralesional therapy is a “targeted form of physician administered, intermittent therapy which is capable of producing a ‘depot’ effect to maintain bioavailability of the drug at the site of action over longer periods of time.” It refers to injection of a higher concentration of a drug directly into the nail matrix, nail bed, hyponychium, or translesionally.

For injections in the nail unit, a 30-gauge needle is recommended, preferably with a 1-mL Luer-lock syringe or insulin syringe equipped with a built-in needle, not only minimizes pain during needle insertion, also prevents needle displacement and backsplash.

Various techniques of administering intralesional therapy in nail diseases are:

- Intramatricial injection
- Intrabed injection
- Intrafold injection
- Hyponychial injection
- Translesional injection
- Needle-free Intradermal injection

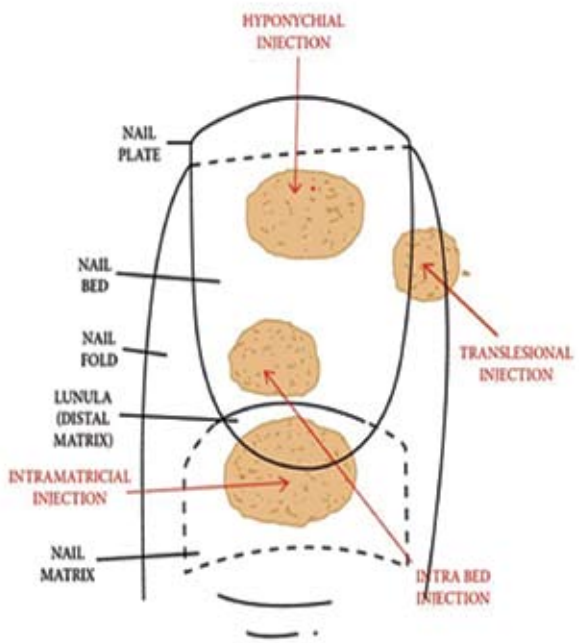


Fig. 1 Techniques of intralesional nail therapy

INTRAMATRICIAL (NAIL MATRIX) INJECTION

It refers to injection of a drug directly into the nail matrix in diseases where the nail matrix is primarily affected.

Indications:

- Nail psoriasis
- Nail lichen planus
- Trachyonychia
- Lichen striatus

The current nail expert group consensus recommends intramatricial injection of TA as the first line of treatment for:

- Isolated classical nail lichen planus (any number of nails)
- Nail psoriasis involving few nails (≤3 nails involved).

Procedure:

- **Grover technique:** under strict aseptic measures, the needle is inserted 2 mm below and lateral to the junction between the proximal and the lateral nail folds into the proximal nail matrix, the drug is slowly injected to infiltrate the matrix.

  Endpoint of injection: a semilunar blanching of the lunula, noticed arising from underneath the proximal nail fold.

After removing the needle, firm pressure is applied over the injection site for approximately one minute to prevent the formation of a hematoma.

- **Gerstein's method of intramatricial injection:** 0.2-0.25ml of drug is injected in an even distribution along a line 3mm proximal and parallel to the anterior nail fold at the level of the nail.
- **deBerker's approach:** involves injecting from both sides to deposit the drug in the nail matrix area.

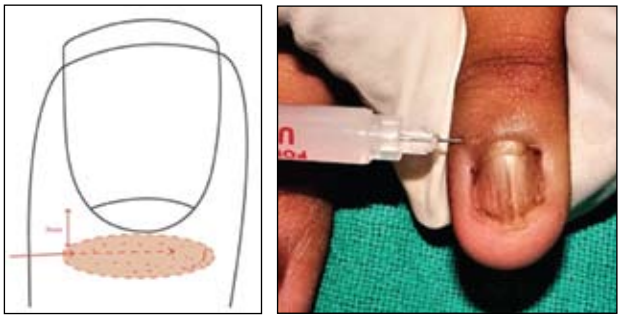


Fig. 2 and 3 Intramatricial Injection

INTRABED (NAIL BED) INJECTION

Here, the medication is deposited directly into the nail bed.

Indication: Nail psoriasis

Useful for nail changes like distal onycholysis, salmon patch, pustules, or subungual hyperkeratosis.

Procedure:

- TA and methotrexate are the drugs which have been used with this technique for treating nail psoriasis

Different approaches:

- Direct penetration of the nail plate
- Injection via the hyponychium
- Injection via the lateral nail fold
- Injection via the proximal nail fold.
- **Injecting medication via the proximal nail fold (Grover 2017a):** the needle is inserted in a manner similar to nail matrix injection, The needle is advanced medially and distally towards the centre of the nail to penetrate the nail bed, it is slowly injected

until saturation. Endpoint is marked by a blanching effect on the nail bed.

- **deBerker technique:** 0.1 mL of TA is injected in each of the four quadrants of the nail unit per session approaching from the lateral nail fold.

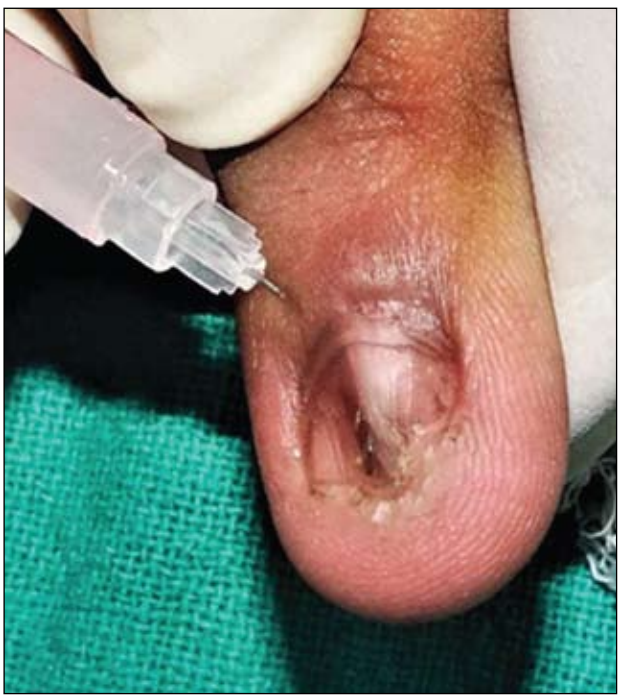


Fig. 4 Intrabed injection

INTRAFOLD INJECTION

This technique involves administering injections into the dermis of the nail fold, allowing the drug to diffuse effectively into the nail matrix and proximal nail bed.

Beneficial for conditions affecting the proximal nail fold and matrix:

- Chronic paronychia
- Hand eczema-related nail changes
- Nail lichen planus
- Trachyonychia
- Nail psoriasis

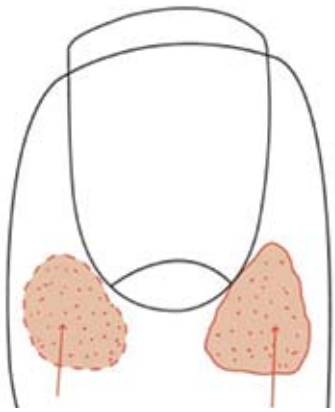


Fig. 5 Nailfold injection

HYPONYCHIAL INJECTION

In this method, the distal nail bed is accessed by way of the hyponychium.

It is useful for distal nail bed changes

- distal onycholysis and subungual hyperkeratosis in psoriasis
- distal subungual warts
- for very large nails (e.g., nails of great toe), where the drug injected into nail matrix or bed might not be sufficient enough to diffuse into the most distal parts of the nail.
- **Richert technique :** injections are administered in each of the four quadrants of the nail in a fan-shaped pattern beneath the nail plate through the hyponychium.

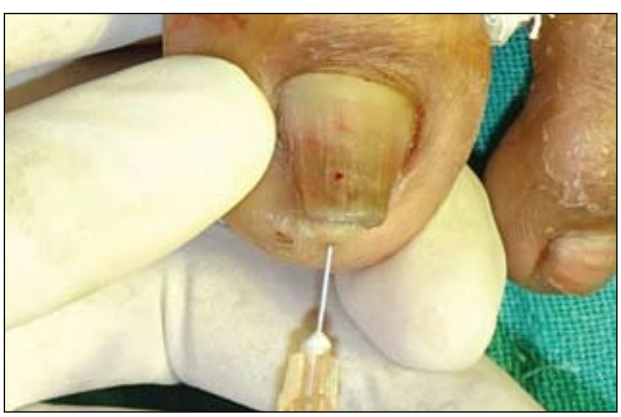


Fig. 6 Hyponychial injection

TRANSLESIONAL INJECTION

For space-occupying lesions involving the nail unit, treatment often necessitates injections directly into the lesion itself, known as translesional injection.

Indications:

- Periungual or subungual warts
- Myxoid pseudocysts involving the proximal nail fold.

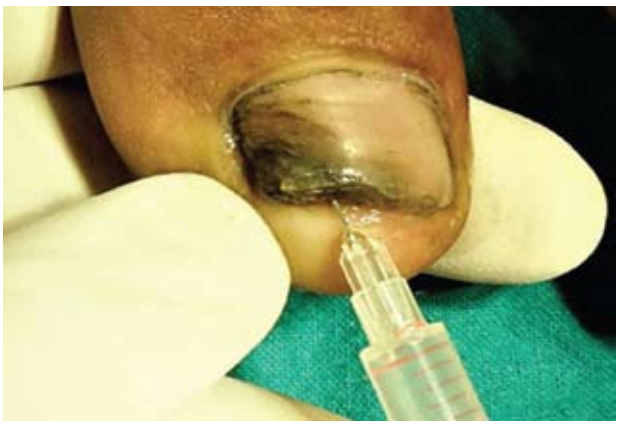


Fig. 7 Translesional injection

- **Intralesional bleomycin:**
- It is a highly effective treatment option for periungual and subungual warts.
- **It performed using various methods:**

1. Direct infiltration involves injecting bleomycin into the wart tissue using a Luer-lock syringe or insulin syringe, which is the preferred technique for subungual warts. This method allows for targeting even subungual warts without the need to remove the overlying nail plate.
2. **The Shelley and Shelley technique of bleopuncture:** applying a drop of bleomycin onto the wart surface and, while keeping the skin taut, making multiple punctures with an insulin syringe to penetrate the wart (40 times per 5 mm^2). This approach is also effective in treating palmoplantar warts.
3. Microneedling with topical spray of bleomycin solution followed by occlusion to facilitate the drug's penetration into the wart tissue.

During bleomycin injection, each wart must be targeted for complete treatment. The endpoint is blanching or yellowish appearance of wart due to vasoconstriction. Following the procedure, the treated areas typically develop a necrotic eschar with occasional bulla formation over the next 2–3 days. Subsequently, the wart tissue shrinks and sheds, leaving behind a brown keratotic scale over smooth skin without bleeding points within 1–2 weeks.

- **Immunotherapeutic techniques for nail unit warts are:** Intralesional
- MMR (Measles, Mumps, Rubella) vaccine
- Mw (Mycobacterium w) vaccine
- Vitamin D injections.

The injection is directly infiltrated into one or two of the largest warts only. It provides the benefit of wart clearance not only at the injection site but also at distant sites.

- **Myxoid pseudocysts:**
- The drug is a sclerosant or triamcinolone acetonide (TA)
- It is directly injected into the cyst cavity following the removal of mucinous material.
- The desired outcome is the pseudocyst displaying blanching and turgidity, signifying proper filling of the lesion.
- immediate compression dressing with an elastic bandage is applied for 24 hours.

Needle-Free Intradermal Injection

Jet injection refers to a method of drug delivery that does not involve needles. It employs a high-velocity stream of fluid containing the medication to pierce the skin and deposit the

drug into the dermis.

Needle-free intradermal injection (NFII) comes in two forms:

- Spring-loaded jet injector (such as Dermojet or Port-O-Jet)
- Gas-powered jet injector.

Advantages:

- These needleless injectors alleviate pain during drug administration
- Ensure more uniform drug distribution within the dermis at the intended depth of penetration.

Disadvantages

- Clogging of the injector
- Backsplash
- Risk of spread of blood-borne infection (because of difficulty in sterilizing the apparatus)

Contraindications for Intralesional Therapy

Absolute

- Known hypersensitivity to the drug used

Relative

- Active infection at the injection site
- Bleeding diathesis
- Peripheral vascular disease
- Raynaud's phenomenon
- Uncontrolled diabetes or hypertension
- Unrealistic expectations of the patient
- Too young and uncooperative patient

- Implantation epidermoid cysts formation following treatment of psoriatic nails requiring amputation.

Indications:

- Intramatricial drug delivery for nail psoriasis

Side Effects of Intralesional Nail Therapies:

Side effects of intramatricial/intrabed injections	Side effects of translesional injection
Local	*Due to bleomycin*
Common	**Common**
Injection site pain (may last for minutes to days, maximum with cyclosporine)	Injection site pain (may last for up to 24 hours)
Transient post injection numbness	Erythema and edema at the site of injection (may last up to 72 hours)
Blackish discoloration (with methotrexate injection) (Figure 19.16)	
Uncommon	**Uncommon**
Subungual hematoma (Figure 19.17)	Severe pain
Traumatic leukonychia	Ulceration at the site of injection
Proximal nail fold hypopigmentation and/or atrophy (Figure 19.18) (with TA if used at too high dosage, too superficial, too frequent, or for too long)	Raynaud's phenomena
	Fingertip gangrene
	Onychomades is
	Scarring and permanent onychodystrophy
Disturbed nail growth (Figure 19.19)	*Due to immunotherapy*
Proximal onycholysis	**Common**
Thinning of nail plate (with TA) (Figure 19.20)	Injection site pain
Splitting and distortion of the nail plate (seen with methotrexate and cyclosporine)	**Uncommon**
	High-grade fever
Acute paronychia (with TA)	Redness and/ or swelling Induration and ulcer formation at the injection site
Rare	*Following treatment of myxoid pseudocyst*
Disappearance of the phalanx under injection	**Common**
Tendon rupture (with TA)	Local pain
Nicolau syndrome (in case of nail matrix injection in lichen planus)	Erythema and/or edema
	Nail fold atrophy/hypopigmentation (with TA)
Systemic	**Uncommon**
Hoigne syndrome	Ulceration and/or necrosis.
Vasovagal attack	
Hypersensitivity reactions	

SUMMARY : Intralesional nail therapy emerges as a promising therapeutic modality for isolated or predominant nail diseases, allowing higher drug concentrations to be injected directly into specific sites of the nail apparatus. It bypasses the drawbacks of systemic administration and avoids the compromised efficacy of topical administration. Success depends on selecting appropriate patients and employing precise techniques.

Dr Chinmai C Chikkalagi
Editor-in-chief
Yuvaderma

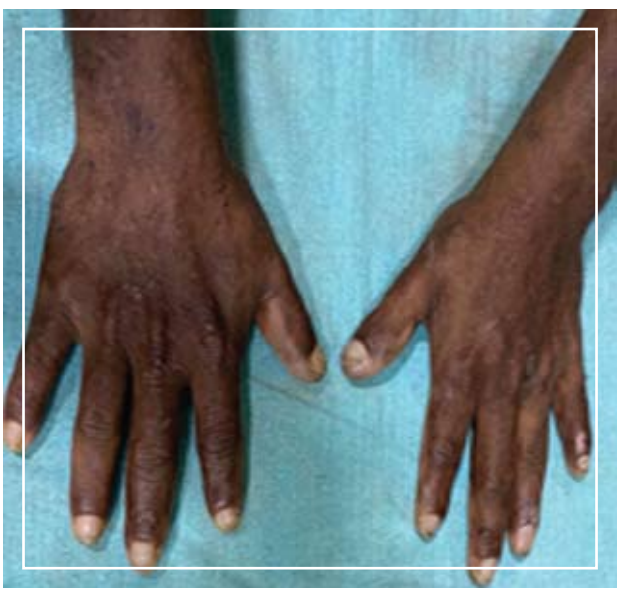
CONGENITAL ERYTHROCYTIC PORPHYRIA

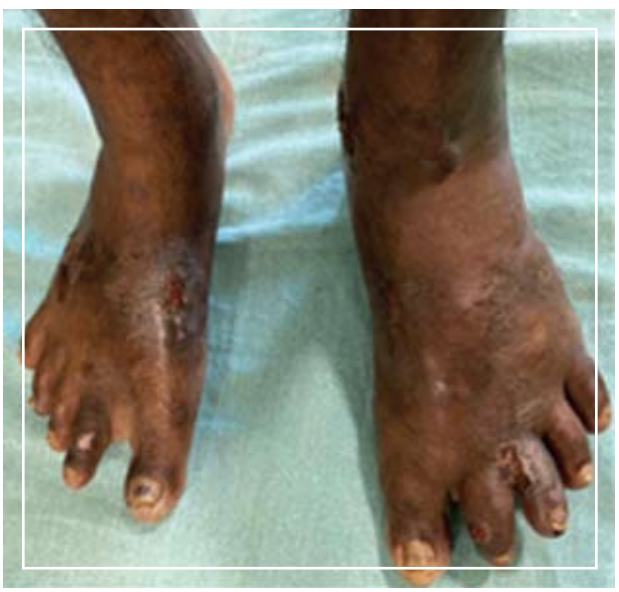
INTRODUCTION : CEP is extremely rare estimating a prevalence of <0.9 in 1000 000. It is X linked inherited disorder due to mutation in GATA1 and amino levulinate synthetase gene mutations.

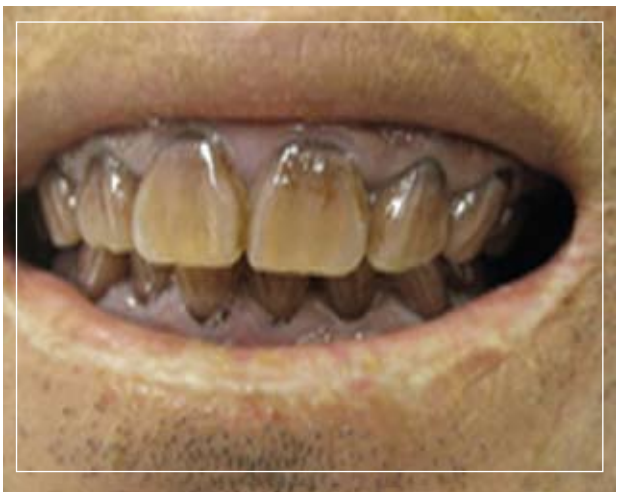
All organs are vulnerable to the porphyrin accumulation effects, but the most affected ones are the skin, teeth hematopoietic system, bones and sclera.

CASE DESCRIPTION : 19 year old male patient came to hospital with complaints of severe cutaneous ulceration and scarring over face and hands accompanied with dyspigmentation. According to Parents skin redness blistering scarring over sun exposed areas and red colour discolouration of urine were noticed at age of 1 year. There was no history of consanguinity or similar complaints in any of their relatives.

O/E: Multiple ill to well defined areas of hyperpigmentation and depigmentation with crusting and scarring distributed over sun exposed areas of face, neck, back and dorsum of hands with significant shortening of fingers, deformity of nose, eyelids edema, scleromalacia and. brown red discoloration of teeth (erythrodontia)







Fluorescence spectroscopy using Wood's lamp revealed simultaneous bright red fluorescence of the teeth and bright green fluorescence of interdigital spaces of the hands

Lab reports showed elevated uroporphyrin and coproporphyrin 1

DISCUSSIOIN : We informed the patient regarding importance of strict photoprotection and was given broad spectrum sunscreens.

Vitamin D supplementation to compensate for lack of sun exposure. Blood transfusions with Deferasirox to chelate iron.

PSYCHOTHERAPY : Patient was offered skin resurfacing treatment which can provide slight improvement to old scar and dyspigmentation.

CONCLUSION : Present case is being reported because of its rarity Since it mimics various other conditions like scleroderma, bullous disorders, photodermatoses, Awareness of this rare entity help to diagnose early.

Dr Fouziya M
KIMS Hubballi

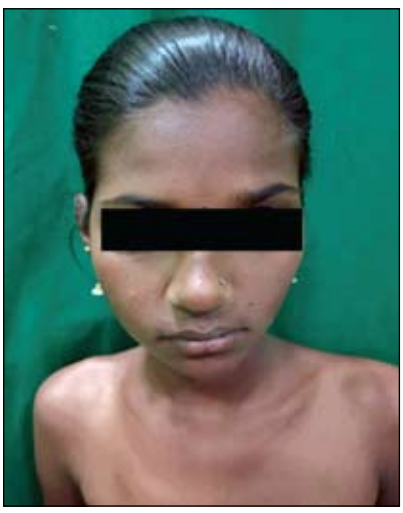
MAFFUCCI SYNDROME - RARE CASE REPORT

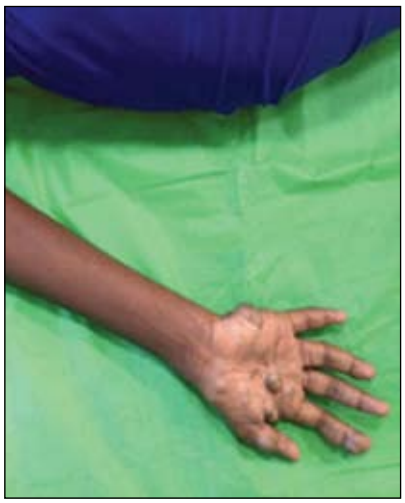
BACKGROUND, Maffucci Syndrome

INTRODUCTION : Maffucci syndrome is a sporadic, non-inherited disease and germline karyotypes are usually normal. The disease appears early in life, around the age of 4–5 years, with 25% being congenital, as a mesodermal dysplasia. Somatic mutations in IDH1 and IDH2 encoding isocitrate dehydrogenase 1 and 2, respectively, have been identified in enchondromas and spindle cell haemangiomas of maffucci patients. Additional genes implicated in the pathogenesis of syndrome may reside on 2p22.3, 2q24.3 and 14q11.2, are altered in enchondromas and spindle cell haemangiomas. Characterized by multiple enchondromas with superficial and deep slowflow venouslike malformations, with spindle cells (spindle cell haemangiomas). Enchondromata, can cause pathologic fractures leading to bony deformation, shortening and difficulty in manipulating objects or ambulating. Because of the multiple spindle cell hemangiomas present in the hands, characteristic calcific phleboliths may be visualized within the vascular malformations. The signs and symptoms progress with time, causing grotesque deformities on the hands and feet. The risk for malignancy increases with age. Mesodermal neoplasms associated include fibrosarcoma, glioma, astrocytoma, ovarian tumours, haemangiosarcoma and leukaemia

CASE : A 14year old female presented with asymmetry of lower limbs since 11 years and asymptomatic raised bluish dark coloured lesions over right dorsum of palm since 8 years

On examination: hemihypertrophy of right side of the face and right side of chest present. Scoliosis present. Shortening of left lower limb present. Multiple, discrete, skin coloured to bluish, non tender, non translucent, immobile, slightly compressible nodules with cysts present over dorsum of right hypothenar eminence, medial border of right thumb, index and





ring finger. There are no associated systemic complaints and complications. Her parents and siblings are normal.

CONCLUSION : Patient can be managed by both dermatologists and orthopedician. Surgical excision of cystic lesions and laser treatment for nodules and smaller lesions can be considered. Prolonged clinical follow-up and imaging studies are necessary.

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A rare case of Chronic granulomatous bacterial infection - "BOTRYOMYCOSIS : A DIAGNOSTIC DILEMMA"

INTRODUCTION : BOTRYOMYCOSIS is a chronic granulomatous and suppurative infection caused by STAPHYLOCOCCUS AUREUS and also by PSEUDOMONAS, E. COLI, PROTEUS, etc presenting as uncommon, chronic, indolent disorder characterized by crusted granulomatous plaques, nodules, ulcers, and sinus tracts draining purulent material. Also called as **ACTINOPHYTOSIS.**

CASE DESCRIPTION : A 33-year-old male patient named Suman who is daily wage laborer by occupation came with chief complaint of painful red raised mass over left Arm since 10 years, increased in size since 1 year. This is associated with dragging type of pain. History of excision 2 years back outside (suspected as **Actinomycosis**) which reappeared again. On cutaneous examination -Single, well defined indurated erythematous plaque soft to firm in consistency, extending from Left mid arm to elbow covering anterior, lateral and posterior aspect of left arm sparing medial aspect measuring 14*17cms with sinuses and crust with yellow colored discharge.

BACTERIAL CULTURE SENSITIVITY : STAPHYLOCOCCUS AUREUS isolated after 24 hours of incubation.

GRAM STAIN : Gram positive cocci, non-filamentous bacteria is seen

FUNGAL CULTURE: Negative

ACID FAST STAIN : No acid-fast bacilli was seen

MYCOBACTERIAL CULTURE : Negative BIOPSY - **BOTRYOMYCOSIS**

CONCLUSION : Cutaneous Botryomycosis Botryomycosis is a chronic and persistent condition that presents with suppurative and granulomatous skin lesions. These discharge serosanguineous and purulent material, admixed with grains (1–3 mm). Treatment is dependent on the area involved, the depth of invasion, whether visceral involvement is present and the bacteria isolated. Debridement and prolonged antibiotic therapy needed.

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"PERIUNGUAL OR SUBUNGUAL FIBROMAS (KOENEN TUMORS) AS AN ISOLATED SIGN OF TUBEROUS SCLEROSIS COMPLEX : A CASE REPORT"

A 42-year-old female patient presented with chief complaint of difficulty in doing regular household work due to subungual growths on both thumb nails. These subungual growths were gradual onset since puberty and were asymptomatic, gradually with time it affects bilateral thumb, the growth became more enlarge and painful which restricted her for doing household works. She had history of 2 episodes of seizures during childhood but was not treated and was not taking any medication. There was no other clinical evidence of tuberous sclerosis complex (TSC), and no additional hamartomas or hypomelanotic ''ash leaf'' macules were found on examination with a Wood's light.

Introduction : Tuberous Sclerosis (TS) is an autosomal dominant, neurocutaneous syndrome marked by benign tumor growth in organs like the heart, kidney, central nervous system, face, and nails, collectively known as Tubereous Sclerosis Complex (TSC).

TSC results from mutations in either the TSC1 or TSC2 genes, which encode the tumor growth suppressor proteins hamartin and tuberin, respectively. These proteins play a crucial role in regulating cell proliferation and differentiation.

Tuberous sclerosis complex (TSC), also known as Bourneville's disease, was initially described by Desiree-Magloire Bourneville in 1880.

Neurologist Vogt later established a diagnostic triad of epilepsy, idiocy, and adenoma sebaceum in 1908.

TSC affects individuals of all races and ethnicities, occurring in both genders.

The estimated live birth prevalence ranges from 10 to 16 cases per 100,000.

Peri-ungual fibroma, recognized as Koenen tumor, stands as a significant criterion in Tuberous Sclerosis Complex (TSC).

Clinical features : Multiple firm, smooth, skin colored to mild reddish periungal non tender verrucous growths were seen on the surface of both thumb nails suggesting of 'Koenen tumours'.

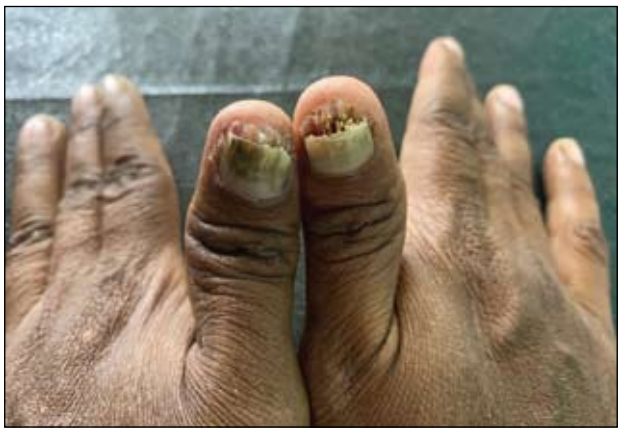
Case report : A 42-year-old female patient presented with chief complaint of difficulty in doing regular household work due to subungual growths on both thumb nails. These subungual growths were gradual onset since puberty and were asymptomatic, gradually with time it affects bilateral thumb, the growth became more enlarge and painful which restricted her for doing household works. She had history of 2 episodes of seizures during childhood but was not treated and was not taking any medication. There was no other clinical evidence of tuberous sclerosis complex (TSC), and no additional hamartomas or hypomelanotic ''ash leaf'' macules were found on examination with a Wood's light.

The family history proved positive for signs of

TSC. Her mother had similar periungual tumors. The patient had two younger siblings, one sister had a seizure disorder from 2 years of age, and the other had a seizure and periungual tumors in adulthood.

Investigations : Examination of her eyes (fundoscopy) and cardiovascular and CNS, were in normal limits. Abdominal ultrasound imaging, X- ray of hand and feet were also normal. CT scan and MRI were not significant. Blood investigation for complete blood count, liver function test, Renal function test, within normal limits.

Discussion : Tuberous sclerosis complex (TSC) is a rare autosomal disorder characterized by multiple growths in various organs. These growths can affect the skin, kidneys, retina, heart, and central nervous system. While only 25% of patients show the classical triad of symptoms, the condition often involves genetic mutations and is linked to chromosomes 9 and 16. One manifestation, Koenen tumors, appears as periungual or subungual fibromas around the nails. These growths can cause cosmetic and functional issues and have been treated with CO2 laser, which offers quicker healing and better cosmetic results compared to traditional surgery. The severity of organ involvement dictates the prognosis, with some severely affected infants not surviving beyond age 10 and most not beyond 25. However, for individuals with late diagnosis and few cutaneous signs, like the case of a 42-year-old woman experiencing difficulty with household tasks due to periungual fibroma without systemic symptoms, the prognosis might differ significantly.



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Persistent Pityriasis rosea – An atypical case presentation

Introduction : Pityriasis rosea is a common acute self limiting papulosquamous exanthematous eruption associated with reactivation of human herpes virus (HHV)-7 and HHV-6[1]. It begins as a solitary oval plaque with a fine collarette of scale("herald patch"). Smaller lesions appear later, along lines of cleavage on trunk ("Christmas tree" pattern)[2].

Case report : A 9 year old female child presented with complaints of itchy skin lesions on trunk, both upper limbs and lower limbs since 2 weeks in the month of February 2022. On examination, multiple well defined erythematous excoriated papules and plaques were seen on trunk, B/L upper and lower limbs. She was clinically diagnosed as pityriasis rosea and was treated symptomatically with antihistamines, topical steroids and a course of oral antibiotics. There was no improvement with above treatment, new lesions continued to appear for 4 months. So we considered differentials of guttate psoriasis, PLEVA and persistent pityriasis rosea and conducted a skin biopsy. On skin biopsy, epidermis showed hyperkeratosis, mounds of parakeratosis, hypogranulosis, moderate acanthosis, spongiosis. Papillary dermis showed perivascular lymphocytic infiltrate, melanin incontinence and extravasation of RBCs. Histomorphological features were suggestive of pityriasis rosea. She was started on antivirals– acyclovir and NBUVB phototherapy following which child showed resolution of lesions.

Discussion : Pityriasis rosea (PR) is a common, self-limiting papulo-squamous disorder, slightly more common in females. In classical

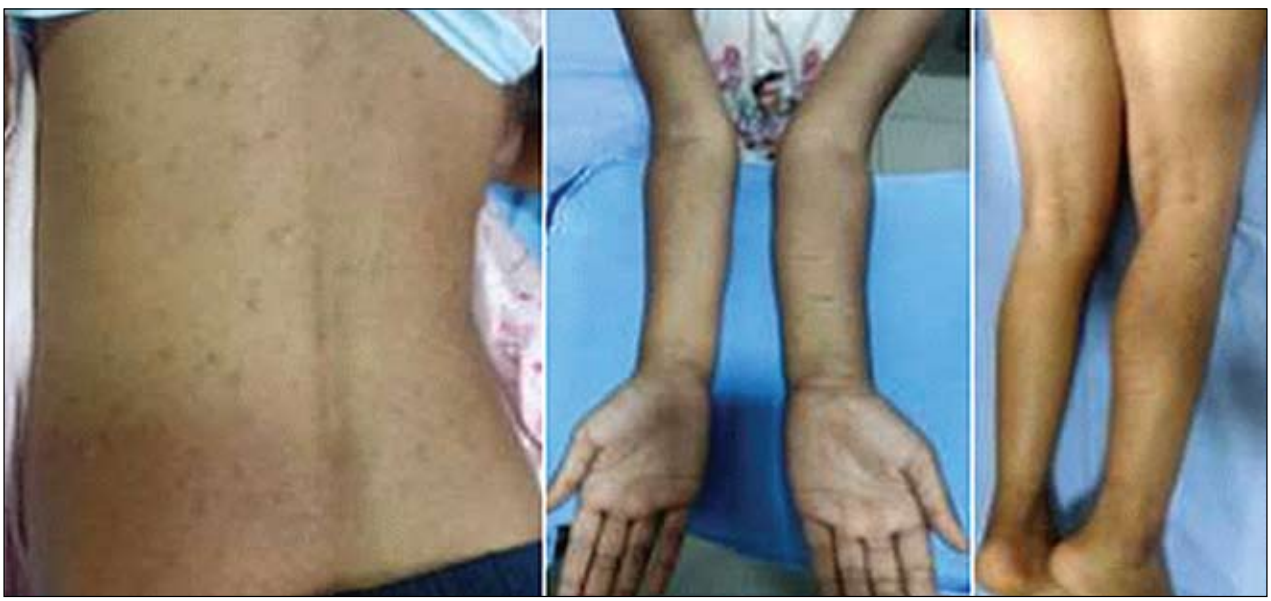

Figure 1,2,3 shows multiple well defined erythematous excoriated papules and plaques seen on trunk, B/L upper and lower limbs.

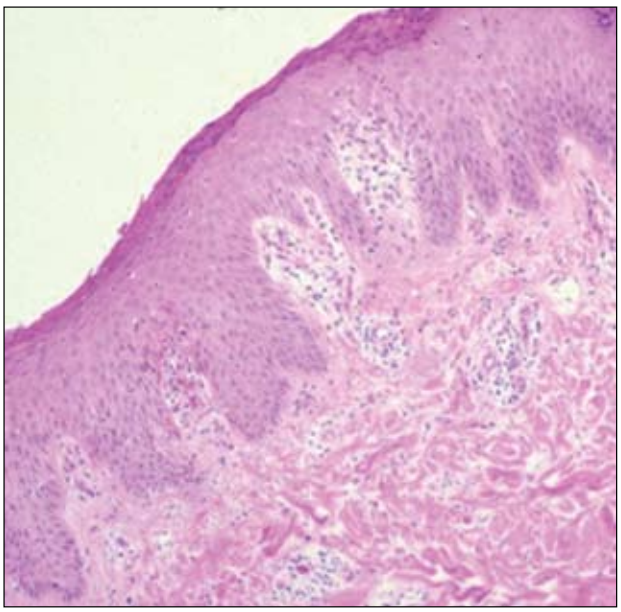

Figure 4 – epidermis showed hyperkeratosis, mounds of parakeratosis, hypogranulosis, moderate acanthosis, spongiosis. Papillary dermis showed perivascular lymphocytic infiltrate, melanin incontinence and extravasation of RBCs

PR, solitary patch termed "herald patch" appears first mainly on the trunk followed by a secondary eruption, characterized by small, pink, oval macules, with a grayish peripheral scaling collarette around them. These secondary lesions are distributed along the cleavage lines of the trunk, ("Christmas tree" pattern). In most cases, the eruption lasts for 6 to 8 wk. Atypical presentation may include unusual morphology, size, distribution or duration of the disease.

Persistent PR is one of the atypical presentations, defined as PR which lasts more than 3 months. Its incidence is 2%. The eruption persists for 12-24 wk[1].

Conclusion : Typical eruptions of pityriasis rosea lasts for about 6-8 weeks although durations as long as six months have also been reported1. Our case also showed atypical presentation as lesions persisted for 5 months.

Dr Krithika

YUVADERMA
E-Bulletin

Sculpting solutions: A surgical symphony in management of Pyoderma gangrenosum

INTRODUCTION : Pyoderma gangrenosum (PG) also described by Brocq and Simon in 1908 as "phagédénisme géométrique is a rare non-infectious neutrophilic dermatosis commonly associated with underlying systemic disease. It has a worldwide estimated incidence of 3–10 cases/million people/year[1]. The incidence of PG increases with age, with a median age of 50 years. It is commoner in females with no association with ethnicity. The pathogenesis of pyoderma gangrenosum is not fully understood. It involves genetic mutations, neutrophil dysfunction, and immune dysregulation, abnormal cytokine signalling by T cells and macrophages. Lesions of pyoderma gangrenosum have been found to have increased levels of inflammatory mediators.[2]

Clinically it presents with rapid progression of a painful necrolytic cutaneous ulcer with an irregular, violaceous and undermined border. Patients with pyoderma gangrenosum exhibit pathergy, a phenomenon whereby skin trauma provokes lesions at the site of injury.

The lower legs are most frequently affected although PG can present at any body site. Subtypes of PG include bullous, vegetative, pustular, peristomal and superficial granulomatous variants.[3] The various treatment modalities for PG include topical corticosteroids or calcineurin inhibitors in combination with systemic corticosteroids, cyclosporine A, azathioprine, cyclophosphamide, mycophenolate mofetil, intravenous immunoglobulins or monoclonal antibodies against TNFα. Surgical therapy is difficult due to risk of pathergy. Nevertheless, after having stopped the inflammation, the ulcers can be treated by split thickness skin grafts and simultaneous immunosuppression.[4]

The following case report highlights acceptance of skin grafting in a patient diagnosed with pyoderma gangrenosum following adequate immunosuppression

CASE REPORT : A 28 year old female was referred from department of surgery in view of progressive non healing ulcers on dorsum of both feet since two months with worsening of ulcer despite regular dressings and appropriate wound care. It started as small elevated lesions which spontaneously evolved into rapidly progressive painful ulcers. All other causes for ulcers were ruled out. On examination – there were two well defined ulcers with irregular margins and peripheral violaceous rim on dorsum of both feet measuring roughly

5.5 x 7.5cms ,floor contained slough and pale granulation tissue. Ulcers were tender and indurated on palpation ,immobile and fixed to surrounding muscle and bone.

A skin biopsy performed from the edge ulcer showed features suggestive of pyoderma gangrenosum with dense dermo-epidermal neutrophilic infiltrate and perivascular lymphocytic infiltrate. Patient was started on tablet methylprednisolone 20mg in tapering doses for 1 month along with capsule minocycline 65 mg once daily for a month. Patient also had regular dressings and appropriate wound management following 1 month of immunosuppressive treatment she underwent skin grafting .Patient was reviewed 10 days, 16 weeks, 24 weeks post grafting. Patient showed signs of graft acceptance and good healing.

Discussion : PG is a clinically challenging frequently misdiagnosed condition with multiple mimickers like infections, vascular insufficiency, tissue injury etc. There are various treatment modalities available for pyoderma gangrenosum.

Debridement of the ulcers should be done gently using Burrow's solution, silver nitrate or potassium permanganate. Topical and intralesional corticosteroids, topical 5-aminosalicylic acid, benzoyl peroxide, topical sodium cromoglycate, intralesional cyclosporine and topical nitrogen mustard can be used. Intralesional corticosteroid injections with triamcinolone acetonide may halt progression of ulcer and induce healing. 10% of 5-aminosalicylic acid suppresses leukocyte motility and cytotoxicity and helps in ulcer regression

Systemic corticosteroids are considered as the drug of choice for the treatment of PG, doses of prednisolone range from 40-80 mg/day. Dapsone in a dose of 100-200 mg/day, Sulfasalazine, sulfapyridine and sulfamethoxypyridazine have been shown to be effective in PG. The beneficial effect is by their ability to inhibit neutrophil chemotaxis

Minocycline in a dosage of 200-300 mg/day is beneficial in PG by its anti-inflammatory effect and by diminishing the chemotactic responsiveness of neutrophils.

Immunosuppressive agents like azathioprine (100-150mg/day), mercaptopurine, cyclopho sphamide (100-150 mg/day), arabinoside, chlorambucil, colchicine and daunorubicin have been used as adjunctive or alternative therapy to systemic corticosteroids with varying success in PG

Plasma exchange, intravenous immunoglo bulin, hyperbaric oxygen therapy, thalidomide, nicotine, and potassium iodide may also been used[5] Wound care and pain control are key features in the treatment of pyoderma gangrenosum Other therapies that have been successful are anti-TNF-alpha drugs such as etanercept and adalimumab.[6]

The ulcers of PG without skin grafting require a prolonged time to heal, being prone to secondary infection, which potentially represents an additional trigger for pathergy. In addition, long-term systemic immunosuppressive therapy is

associated with adverse reactions necessitating other treatment modalities[7]. Recent advances have suggested a surgical approach of PG with split thickness skin grafting (STSG) as a safe and valuable treatment if performed under adequate immunosuppression. A case report by Ilknur Altunay et al demonstrated a case of colorectal adenocarcinoma with PG, who responded partially to topical treatments and systemic immunosuppressants and healed completely with surgical wound repair and hyperbaric oxygen therapy. Patient was given tablet prednisolone and cyclosporine for a month prior surgery following which they noticed complete healing and excellent aesthetic outcome[8]

A study done by Cliff, S et al demonstrated that split skin grafts were a useful treatment modality in 4 patients with ulcerative PG, producing a good cosmetic result. One case illustrated the importance of ensuring the disease is quiescent prior to grafting, to avoid pathergy. The other cases emphasised the need for prolonged immunosuppressive therapy to minimise the chance of reactivation of the disease process. They also concluded that the ultimate cosmetic result was superior after immunosuppression[9]

Another study evaluating efficacy of skin grafting in pyoderma gangrenosum in 153 patients found complete healing of wounds in 75.5% patients. The average time to complete healing was 10.8 weeks, mean donor site healing time was 1.9 weeks. Pathergy was reported in 8 (5.2%) patients.

A statistically significant difference in the number of patients receiving preoperative and postoperative immunosuppressive therapy was found between the groups with complete healing/reduction and no improvement/ aggravation[10]

While surgical treatment is supported by the published data, the exact dose and duration of required immunosuppression is still evolving.

Conclusion : In the above reported case, good surgical outcome was observed post surgery after an immunosuppressive therapy for 1 month. To limit the risk of pathergy developing, a role for prolonged courses of immunosuppressive therapy is suggested in previous literature. The most effective dose and duration of immunosuppressive therapy in patients with PG treated with split skin grafts remains to be determined

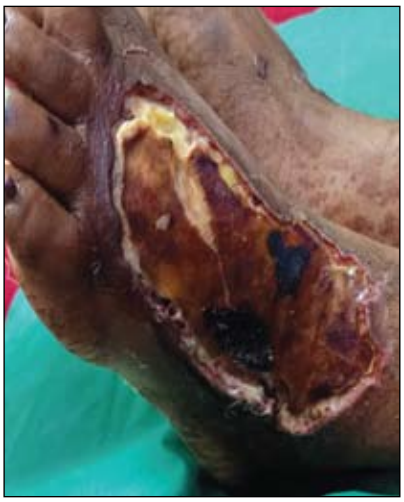

FIG 1 - AT PRESENTATION - well defined ulcers with irregular margins and peripheral violaceous rim on dorsum of both feet measuring roughly 5.5 x 7.5cms. Floor contained slough and pale granulation tissue

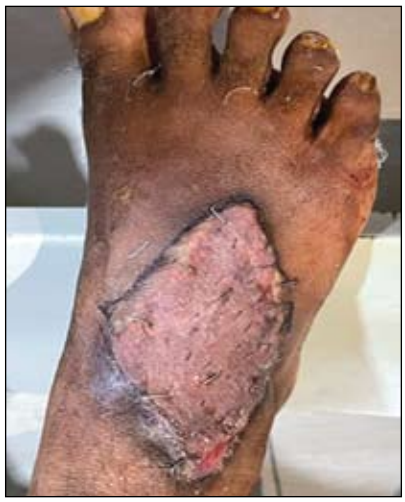

FIG 2 - 10 DAYS POST GRAFTING

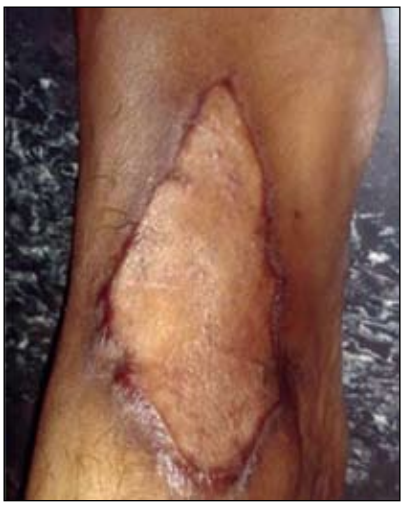

FIG 3 - 16 WEEKS POST GRAFTING

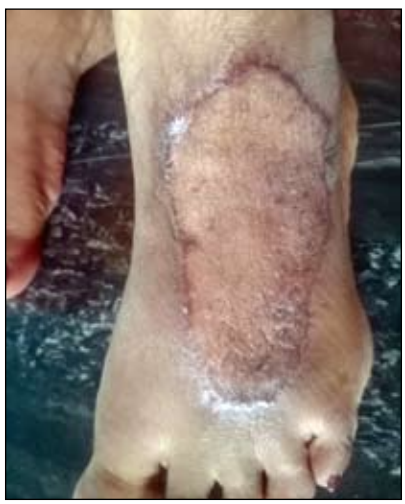

FIG 4 - 24 WEEKS POST GRAFTING

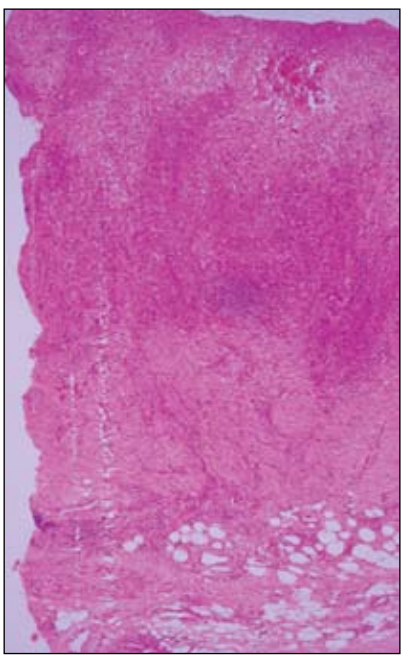

FIG 5 - HISTOPATHOLOGY 100X VIEW - dense dermo-epidermal neutrophilic infiltrate and perivascular lymphocytic infiltrate

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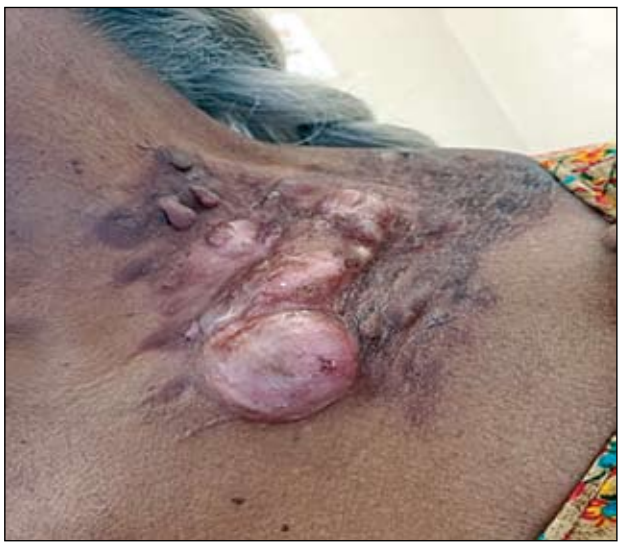
A case series on Dermatofibrosarcoma protuberans

Dermatofibrosarcoma protuberans (DFSP) is rare locally aggressive malignant cutaneous soft-tissue sarcoma. DFSP develops in connective tissue cells in dermis. Autocrine overproduction of platelet-derived growth factor is responsible for growth.



Case report :

1. 65yr female presented with gradually enlarging asymptomatic skin lesion on left shoulder since 20 yrs. O/E-few erythematous to hypopigmented rubbery mass with largest measuring 6X5cm were noted with surrounding ill defined brownish plaques on left shoulder. Biopsy-spindle shaped cells with elongated nucleus arranged in cartwheel pattern was noted in dermis.

Conclusion :

Wide excision of lesion including deep fascia, with 1-3 cm margin of normal skin. Radiotherapy is sometimes used in addition to surgery.

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Davanagere

"UNVEILING THE NAIL TALES : DECODING LICHEN PLANUS - INDUCED TRANSFORMATIONS IN NAIL MORPHOLOGY"

INTRODUCTION :

Lichen Planus (LP) is a chronic, inflammatory autoimmune skin condition impacting skin, mucous membranes, hair, and nails, with nail involvement in 10% of mucocutaneous LP cases.

Isolated Nail Lichen Planus (NLP) is a rare and disabling disease, manifesting in nail matrix or bed, presenting as thinning, onychorrhexis, trachyonychia, longitudinal melanonychia, and severe anonychia.

Diagnosis and treatment planning require onychoscopy and histology due to overlapping features with other nail disorders.

Limited literature on NLP exists, mainly comprising small case series and two retrospective studies - one from Italy (20 years, 75 patients) and another from France (12 years, 67 patients). This study includes 15 patients with isolated NLP, aiming to shed light on the diagnostic and therapeutic implications.

CASE REPORT :

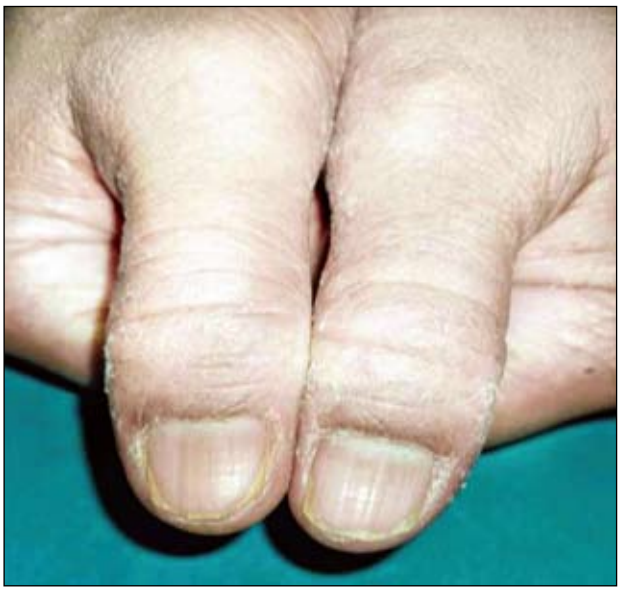
Fifteen patients diagnosed with lichen planus and presenting with nail changes were included in this case series. Detailed clinical examinations, including nail assessment, were conducted. Histopathological analysis of nail biopsies was performed to confirm the diagnosis and identify characteristic features of lichen planus involvement.

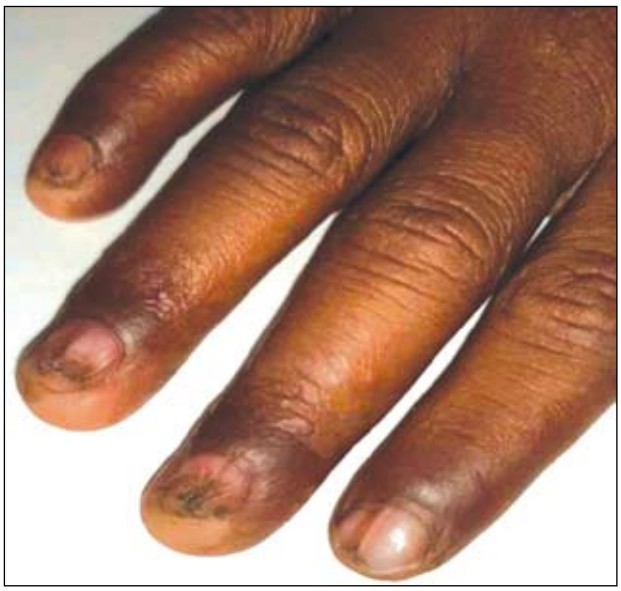
RESULTS :

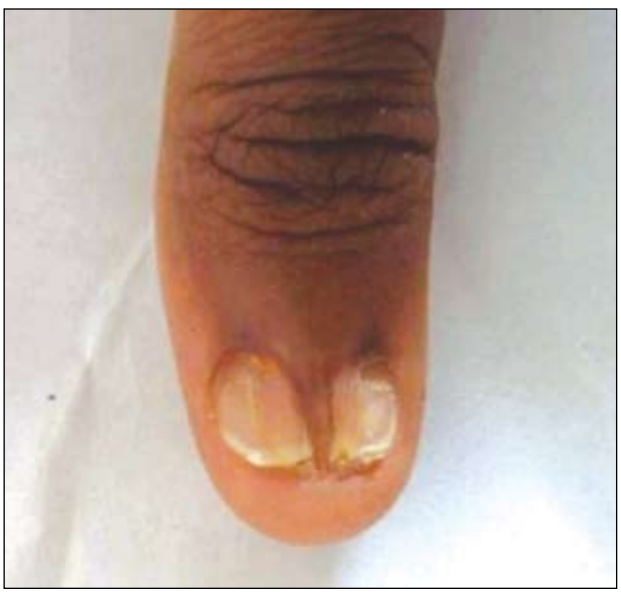
The study cohort consisted of 8 females and 7 males, with an age range of 25 to 65 years. The duration of lichen planus varied from 6 months to 3 years. Nail changes observed included longitudinal ridges (73%), pitting (60%), onycholysis (40%), subungual hyperkeratosis (33%), and nail plate thinning (20%). The majority of patients presented with involvement of multiple nails, predominantly affecting the fingernails.

CONCLUSION :

Nail changes in lichen planus are diverse and may present as a diagnostic challenge. Recognizing these manifestations is crucial for accurate diagnosis and appropriate management. This case report provides valuable insights into the clinical and histopathological aspects of nail involvement in lichen planus, aiding clinicians in the identification and treatment of this often-overlooked aspect of the disease. Further research is warranted to elucidate the pathogenesis and optimal therapeutic strategies for lichen planus affecting the nails.







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MNEUMONICS - I

Psoriatic arthritis - CRAMS

Classical
Rheumatoid arthritis like
Asymmetrical oligoarthritis
Mutilans
Symmetrical arthritis

Drug causing psoriasis -

LiAM Beta ACEd (lithium, antimalarials, beta blockers, ACEI) Layers of epidermis (I-O)

Banaras Saree Gets Costly (basale, spinosum, granulosum, corneum)

Longitudinal melanonychia causes -

DRIP TRIP
drugs
Racial
Idiopathic
Pregnancy
Trauma
Radiation
Inflammation
Peutz jegher syndrome

Darier disease (DARIER)

D- dirty warty papules,dyskeratoses
A-,ATP2A2,acantholytic
R-ronda, corps, grains
I- insufficient calcium
E- hEReditary (AD)
R- Red and white longitudinal streaks on nail
PI.ANoo
Posterior leg - erythema Induratum
Anterior leg - erythema Nodosum

DD of hypopigemented lesions

VITALC
vitiligo
IGH
T.versicolor
Alba (pityriasis)
Leprosy
Congenital marks

EID in PASI

Erythema
Induartion
Desquamation

Treatment in hirsutism - A.E.I.O.U

anti androgens
Eflornithine
Insulin sensitisers
Ocp
glUcocorticoid

Nevus of OTA - Around The Orbit

Nevus of ITO- In TOraco
Types of Nevus

ABCDH

anemicus
Beckera
Comedonicus
Depigmentosus
Halo

Scarring alopecia -
Pseu D Centre for Li & Fol
(Sue d centre for lying & following)
Pseudopelade of brocq
DLE
Central centrifugal alopecia
Lichen planopilaris
Folliculitis decalvans

DDs of pustular lesions in pediatric population
MET VIA CSF

milia, miliaria
Erythema toxicum neonaturum, eosinophilic folliculitis
Transient neonatal pustular melanosis
Varicella
Impetigo
Acne
Candidiasis
Syphilis
Folliculitis

Dr. Vyjayanthi
JR3, Akash Institute of Medical Sciences and Research Centre

MNEUMONICS - II

1. SYNDROMIC ICHTHYOSIS:

"Children Con & Kid were Lost in Camel Ride. Try If Erie Larsson Know where they are."

- children - CHILD syndrome
- Con - Conradi- Hunerman happle syndrome
- kid - KID syndrome
- lost - Loricrin keratoderma
- camel - comel- Netherton syndrome
- ride - Refsum disease
- try - Trichothiodystrophy
- if - IFAP syndrome (Ichthyosis follicularis/ atrichia/ photophobia syndrome)
- Erie - Erythrokeratoderma variabilis
- Larsson - Sjogren Larsson syndrome
- know - neutral lipid storage disorders.

2. DARIERS DISEASE:

"Cobbler Serca HAD Round Grains in her Vault telling AS Vitamin Pills."

- Cobbler - cobblestone appearance of palate and mucosa
- Serca - SERCA -2 abnormality
- H - Heat exacerbated
- AD - Autosomal dominant, Acantholytic Dyskeratosis
- Round grains = corp ronds and grains in histopathology
- Vault - 'V' nicking of nails
- A - ATP2A2 gene mutation
- S - Seborrheic area involvement
- Vitamin - Vitamin A (retionoids) and E for management
- Pills - Palmar pits

3. PERFORATING DERMATOSES:

"PERK"

- P - Perforating folliculitis
- E - Elastosis perforans serpiginosa
- R - Reactive Perforating collagenosis
- K - Kyrles disease

4. FACIAL MELANOSIS:

"LEARN PEM (protein energy malnutrition)"

- L = Lichen plano pigmentosus
- E = Erythema dyschromicum perstans, Erythromelanosis follicularis faceii et coli
- A = Acanthosis nigricans
- R = Riehl's MELANOSIS
- N = Nevus of ota, Hori Nevus
- P = Post inflammatory hyperpigmentation, Peri orbital melanosis, Pigmentary demarcation lines, Poikloderma of civatte.
- E = Exogenous oochronosis
- M= Melasma

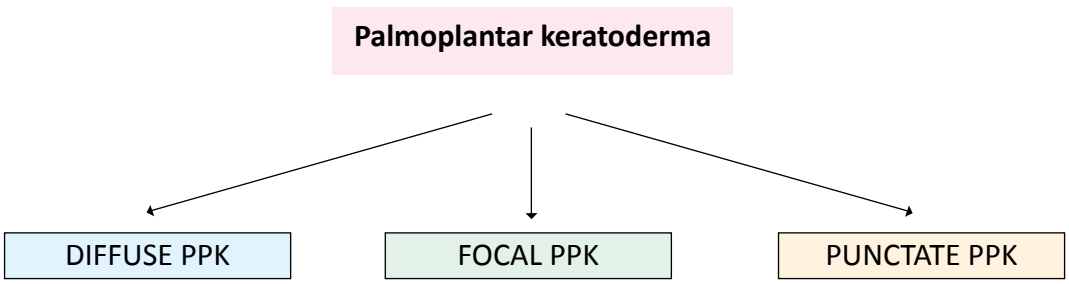
5. DRUGS CAUSING ACNEFORM ERUPTION:

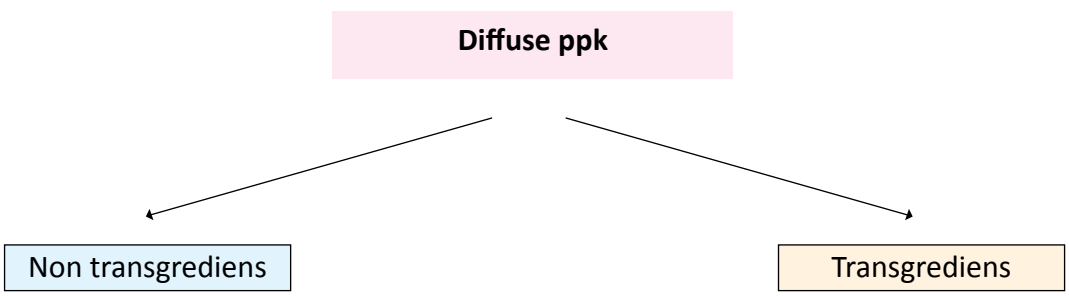
"NIPAH in CaVE"

- N = Neuropsychiatric drugs : lithium, valproate, phenytoin, TCAs
- I = Immunomodulatory drugs : cyclosporine, azathioprine
- P = PUVA therapy
- A = ATT drugs : isoniazid, rifampicin, ethionamide

- H = Halogens : iodides, bromides, radioactive substances
- Hormones : corticosteroids, anabolic steroids, androgens, danazol, oral contraceptive pills, growth hormones.
- C - Chemotherapeutic agents : thiouracil, imatinib
- V - Vitamins B1, B6, B12
- E - Epidermal growth factor receptor inhibitors

DIFFICULT TO REMEMBER PPK TYPES?... NOT ANYMORE...!!!





Nano U V

Nano - NAXO'S DISEASE

U - UNNA THOST DISEASE

V - VORNER'S SYNDROME

CM GP WON Big Hyundai Car

C - CAMISA SYNDROME

M - MAL DE MELIDA SYNDROME

G - GREITHER'S SYNDROME

P - PAPILLON LEFVRE SYNDROME

V - VOHWINKEL'S SYNDROME

O - OLMSTED SYNDROME

N - NAGASHIMA SYNDROME

Big - BART- PUMPHREY SYNDROME

Hyundai - HURIEZ SYNDROME

Car - CLOUSTON SYNDROME

FOCAL PPK

WITH ASSOCIATED FEATURES

HalF PCR

H - HOWEL EVANS SYNDROME

F - FOCAL KERATODERMA WITH LEUCOKERATOSIS

P - PACHYONYCHIA CONGENITA 1 AND 3

C - CARVAJAL SYNDROME

R - RICHNER HANHART DISEASE

WITHOUT ASSOCIATED FEATURES

FOCAL EPIDERMAL PPK

STRIATE PPK

PUNCTATE PPK (PPPK)

WITHOUT ASSOCIATED FEATURES

Bb - BUSCHKE FISCHER DISEASE

M - MARGINAL PAPULAR ACROKERATODERMA

P - PUNCTATE KERATODERMA OF PALMAR CREASES

WITH ASSOCIATED FEATURES

PPPK WITH FACIAL SEBACEOUS HYPERPLASIASTRIATE PPK

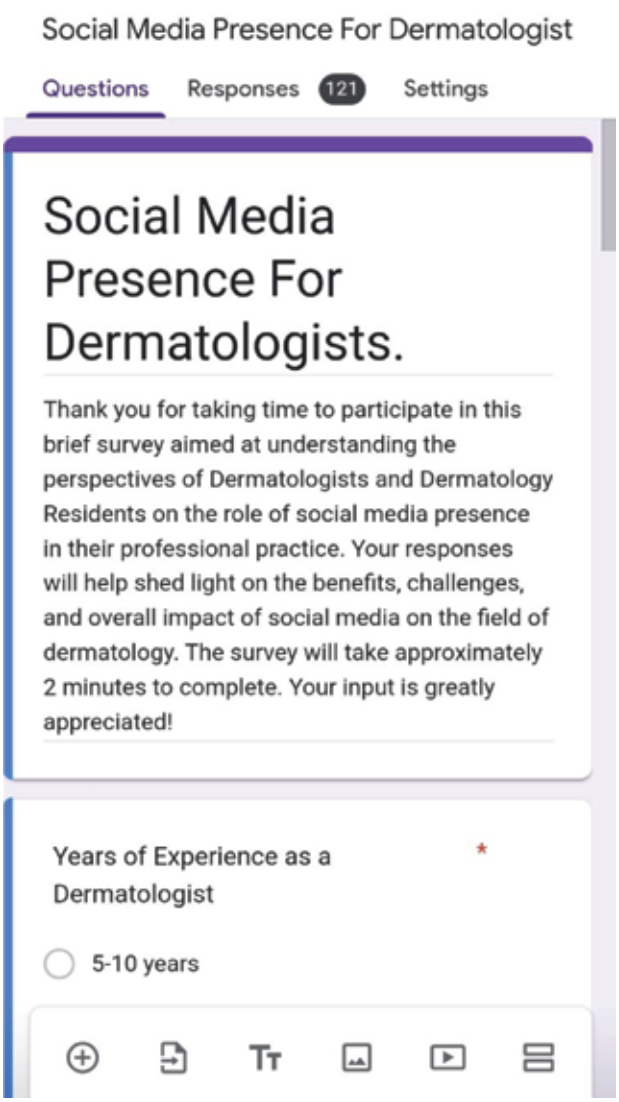
PPPK WITH ANKYLOSIING SPONDYLITIS

PPPK WITH LIPOMATA

PPPK WITH SPASTIC PARALYSIS

Dr. VINAY KUMAR M V
MIMS, MANDYA

SOCIAL MEDIA PRESENCE


Social Media Presence For Dermatologist

Questions Responses 121 Settings

Social Media Presence For Dermatologists.

Thank you for taking time to participate in this brief survey aimed at understanding the perspectives of Dermatologists and Dermatology Residents on the role of social media presence in their professional practice. Your responses will help shed light on the benefits, challenges, and overall impact of social media on the field of dermatology. The survey will take approximately 2 minutes to complete. Your input is greatly appreciated!

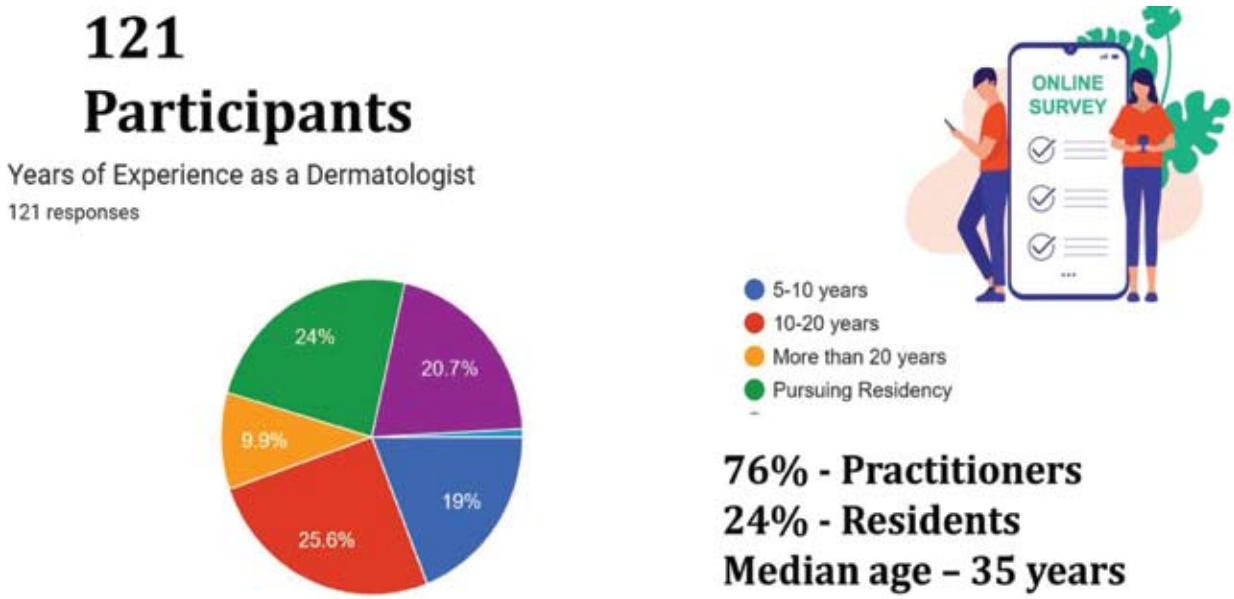
Years of Experience as a Dermatologist *

5-10 years

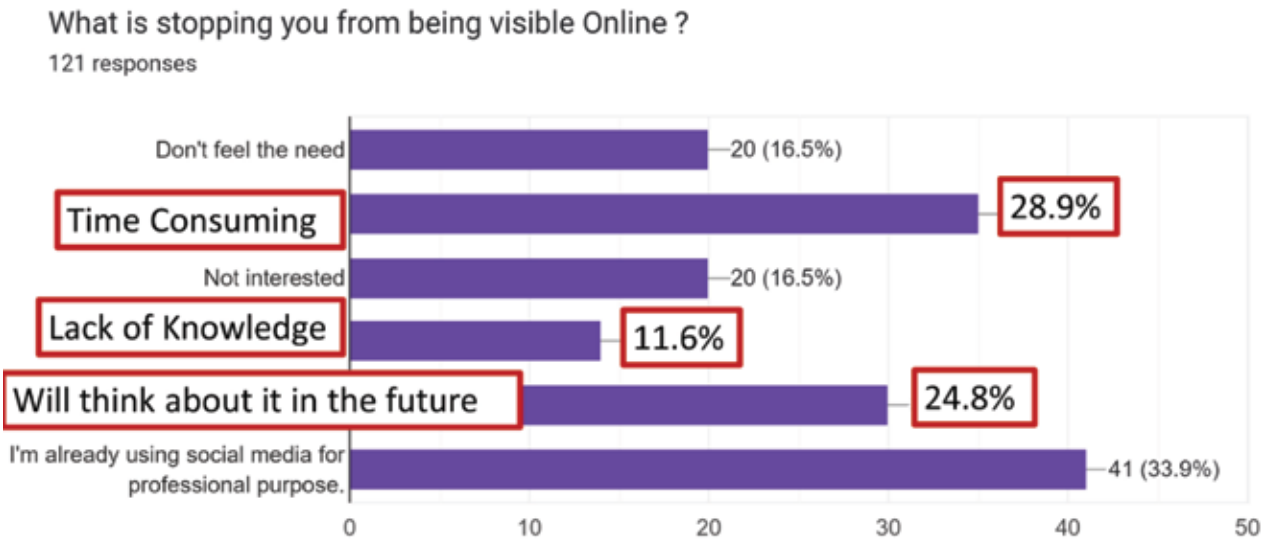
Social media has become an integral part of our societal tapestry, seamlessly integrating itself and steadily gaining momentum since its inception. As of March 2023, there are a staggering 4.48 billion active social media users worldwide, representing over 50% of the global population. This figure nearly doubles what it was just five years prior, in 2017.

The advantages of maintaining a social media presence are manifold. It enables one to reach new patients, enhance their reputation, facilitate easier communication with patients, and effectively showcase their expertise. However, along with these benefits come certain drawbacks. Managing one's online reputation can prove to be a daunting task, privacy concerns loom large, it can consume significant amounts of time, and measuring the return on investment can be challenging.

We conducted a survey to gather insights from practicing dermatologists and dermatology residents regarding their views on having a social media presence.



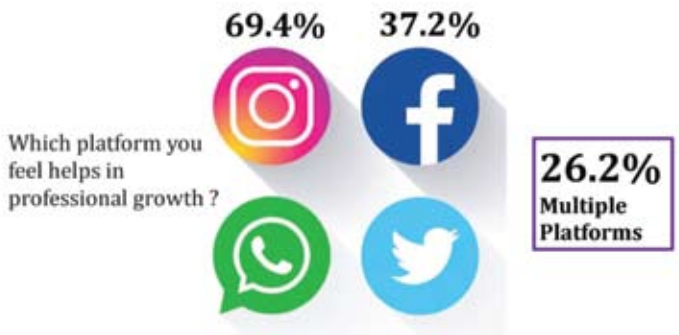
Among the respondents, 39.7% hailed from institutional practices, while 34.7% practiced privately, indicating a diverse representation across different practice settings. Interestingly, approximately 40% of participants perceived social media as moderately impactful in disseminating knowledge about skin conditions, underscoring its potential as an educational tool within the field. Furthermore, a significant majority, comprising 52% of participants, utilized social media as a platform for professional growth, recognizing its efficacy in networking and cultivating their professional image. However, barriers to entry persisted for some, with common reasons for abstaining from social media presence including time constraints, inadequate knowledge, and a desire to explore its potential in the future, as indicated by 24.8% of respondents.



The survey also shed light on the multifaceted nature of social media usage among dermatologists. While 24% leveraged social media for brand building, a staggering 82% utilized it primarily for spreading awareness about dermatological issues, underscoring its role as a tool for public health advocacy.

Privacy concerns, a perennial issue in the digital age, seemed relatively mitigated, with 74% of respondents reporting no challenges in this regard. However, the matter of patient consent emerged as a notable concern, with 19% of doctors admitting to posting patient pictures without prior consent, while only 28.4% ensured written consent before sharing such content.

When queried about the platform most conducive to professional growth, a significant proportion (69.4%) identified Instagram as their preferred choice, followed by Facebook (37.2%), and a notable 26.2% who favoured multiple platforms. Despite this, 43.8% expressed uncertainty regarding the positive impact of social media on their professional reputation, reflecting the ambiguity surrounding its efficacy as a branding tool.



My take - Young dermatologists should consider integrating Clinical knowledge, financial literacy and social media to effectively navigate the ever-evolving branch.

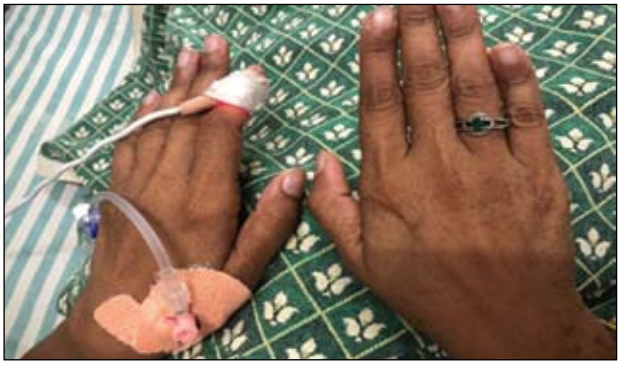
Whether you choose to utilize social media for professional advancement is a personal decision. However, it's crucial to maintain ethical practices and bear in mind that while trends evolve, fundamentals endure

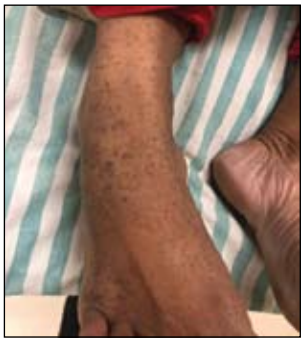
Dr. Jinisha Anand Jain
Junior Resident
Jawaharlal Nehru Medical College, Belagavi

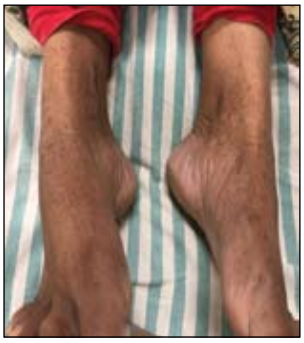
Reticulate Acropigmentation of Kitamura: A CASE REPORT

Reticulate acropigmentation of Kitamura (RAK) is a rare pigmentary disorder that has an autosomal dominant pattern of inheritance. RAK was found to be caused by mutations in ADAM10 gene. Although number of cases are seen in countries like Japan, it's a rare case in India. Here we present a case of Kitamura. First case was described in 1943 by Kitamura and Akamatsu. In 1953, seven further cases were reported by Griffiths, were first to be described outside Japan.

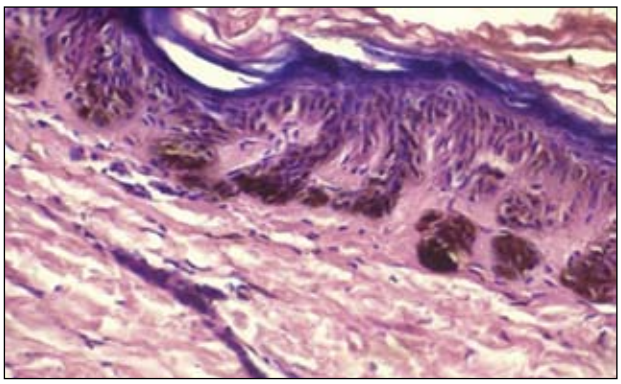
CASE REPORT : A 35-year-old female presented with complaints of asymptomatic skin lesions on body since 20 years. Patient noticed few dark colored skin lesions on dorsum of hands around 20 years back, insidious in onset gradually progressive to involve the upper and lower limbs. She noted gradual darkening and increase in size of those lesions in the coming years. History of similar complaints in mother. On cutaneous examination multiple reticulate atropic hyperpigmented macules of varying sizes were noted on dorsum of hands and foot. Few such lesions were noted on upper and lower extremities.







HISTOPATHOLOGY : Biopsy showed hyperkeratosis of stratum corneum, slight atrophy of the malphigian layer, and irregularly elongated rete ridges. Focal melanin clumps in the upper layers of the epidermis with excessive melanization of the basal layer, melanin incontinence in the upper dermis seen.



Discussion : A 35-year-old female presented with pigmentary changes since last 20 years. Initially, the lesions were present over dorsum of hands and gradually they increased in size as well as number to attain the present status. Cutaneous examination revealed sharply demarcated atrophic hyperpigmented macules over the dorsum of extremities. There wasn't any hypopigmented lesion anywhere. Chest,

abdomen, lower extremities and flexures were spared. Examination of hair, nail and mucosa did not reveal any abnormality. Her mother had similar lesions. Based on these findings, a diagnosis of Reticulate acropigmentation of Kitamura is considered.

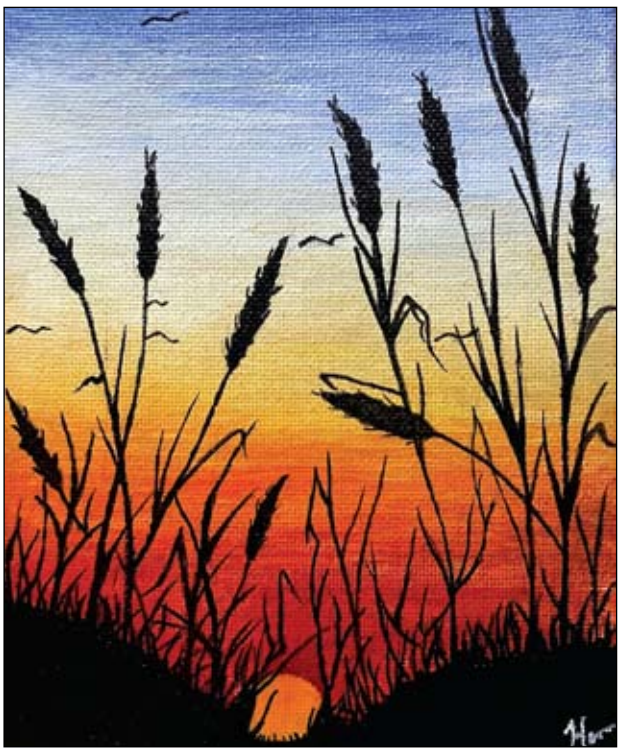
Important clinical differential diagnoses include -

1. Dyskeratosis congenita (poikiloderma, leukoplakia and nail dystrophy),
2. Dowling Degos (reticulated hyper pigmen tation of major flexures, comedones on the back and neck and pitted facial scars),
3. Dyschromatosis symmetrica hereditaria (symmetrical hypo and hyperpigmentation of distal extremities, especially dorsal aspects of hands and feet but palms, soles and mucous membranes are spared),
4. Dyschromatosis universalis hereditaria (generalized hyper-and hypopigmented macules; can occur on palms and soles, but not mucous membranes,hair and nail involvement can be there).

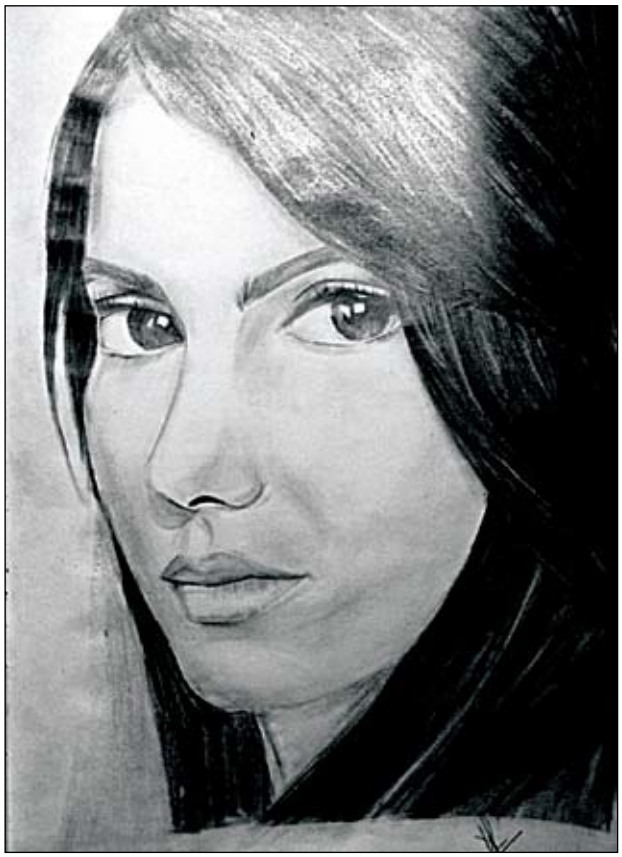
CONCLUSION : RAK lesions slowly darken over time. Above mentioned lesions can also be seen in Dowling Degos disease, dyskeratosis congenita, dyschromatosis symmetrica heriditaria, dyschromatosis universalis heriditaria and we keep RAK as one of our differential diagnosis. Proper evaluation and genetic counselling is required. Most treatment attempts have been unsatisfactory although adapalene, systemic retinoids, 20% azelaic acid can be tried.

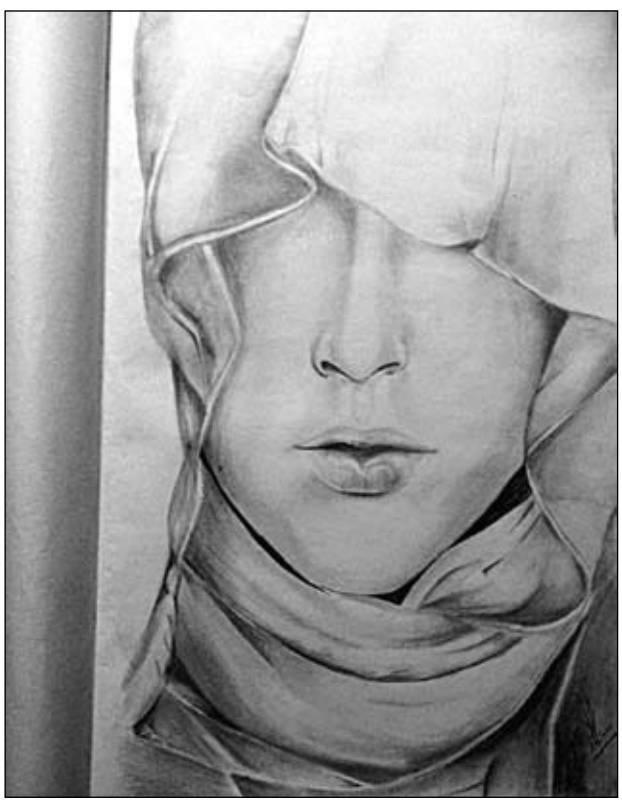
Dr Sheethal C H
3rd year PG, SSIMSRC,
Davangere

Creative constellations A collection of art



Dr. Hemavathy B K
Senior Resident
KOIMS, Madikeri





Dr Mahima M M
First year PG
KIMS, Hubli

Dr Manisha M

Dr. Tejashwini
2nd year PG, KIMS,
Hubballi

Dr. Tejaswini Anoop
2nd Year PG
KIMS, Hubballi

Dr. Meghana R
1st Year, Junior Resident
KIMS, Hubli

Harmony of words: A collection of poems

Night Dance

Beneath the Skin, they start to dwell,
Strongly matched by Mites to tell.
Between Fingers, toes, Armpits,
Dancing itch present for Nights.

Itching Scartching and Scratching Itching,
Persisting Mites beyond belief,
Fighting a Battle that never Relief,
With Tiny Creatures making all Grief.

To soothe the itch, to heal the Wound,
Present Remedies Around.
With Care, Patience and Love we Treat,
For Scabies we all want to Beat.

Dr. Arpita Chavhan

WHISPERS OF SKIN

In the realm where skin speaks, in wrinkles & hues,
A canvas of life, bearing old tales and news.
Elastic and vibrant, it stretches and folds,
In its layers and stories, beauty it holds.

Under the sun's kiss, it bronzes and burns,
Under the moon's gaze, it rests and it yearns.
A tapestry woven from genes and from care,
Every texture and color, uniquely rare.

With creams and with serums, we tend to its needs,
From the harshness of winter, to summer's deeds.
In hydration's embrace, it finds its youth,
A testament to care, a beacon of truth.

In the art of dermatology, skin finds its voice,
Celebrating its diversity, every shade by choice.
From the blush of a cheek, to the lines of age,
Every chapter embraced, on life's vast stage.

Dr. Ashmika Shetty
2nd year PG
KIMS, Hubballi

This too shall pass...

Sun, rain, thunder
Come what may ever
Face it with no fear
This too shall pass

Things are in your favour
Wait for blooming flower
The testing is forever
This too shall pass

Live in the present
Enjoy with no resent
Life of happy & content
This too shall pass

Focus on the reality
Trust the process of
ALMIGHTY
Dear,
This too shall pass.

Dr. Vyjayanthi
JR3, Akash Institute of Medical Sciences and Research Centre

MY SKIN DOCTOR

My body is a canvas of untold stories,
stories that surface, but want to be buried,
Stories that the world is curious to learn about,
Stories that don't speak much, but stories that sure shout.

A scar from when I barely knew how to walk,
A mark from when they said, too much I talk,
A blemish on my arm, when I was cooking to please,
And a fun one too, shhh, it's a secret of my happy tease.

Some stories I wish, they never remained,
Some stories on my skin, I wish were detained,
Some I only want to say, when I am twice asked,
Some won't leave me, I know, I want them masked.

I wish to change the scenes on my canvas at last
Don't know who can help me, but I want to change, fast,
This lady close to my home, she says she can help me firm,
She's quite a nice lady, and oh yes, she's a derm.

My skin doctor, I met her, is my heroine in disguise,
She told me, she's there for me, and she's wise,
She said for how much ever long it takes for me to prove,
She will stand by me as in time I improve.

And in time not just did the spots on my skin fade away,
My self confidence grew, I became free, danced and swayed,
I was better within and out, no an inkling of a doubt,
She even gave me a filler, carved me a perfect pout.

Beauty is within, yes all that is true,
There's beauty on the outside, let's face it, it's true,
My derm knew better and she understood me well,
It is because of her that in pride now I swell.

I party with a smile and wear my little black dress
I have a long line of suitors, they just want to impress,
The lingering stories on my skin are now told at my will,
My skin doctor changed me for good ol' still.

I saw her on the road, as years later went by,
She just went about her day like my granny's lullaby,
Remembered and known, a very dear part,
My derm will always be close to my heart.

Dr. Shweta Jain
Dr swetha Skin Care,
Bhuleshwar, Mumbai,
Maharashtra

NAIL

Your are aesthetic
Always protecting!
You are cosmetic
Never stop growing …

Your hurt is widely visible
Your are radiant!
Taking care as u r valuable
Yet transparent…

You are a beautiful nail!!!
Your priority is our smile…

DERMA.!!

Hey there, vitiligo!
Y do u come & go

Hello, psoriasis!
Curing u is bliss

Ola, pemphigus !
& ur homologous

Oho, sunburn!
Being a stubborn

Whatsup, LP!
U r famous 6P.

Acne, Aloha!
Use Bha AHA

Urticaria, bonjour!
Takes a detour

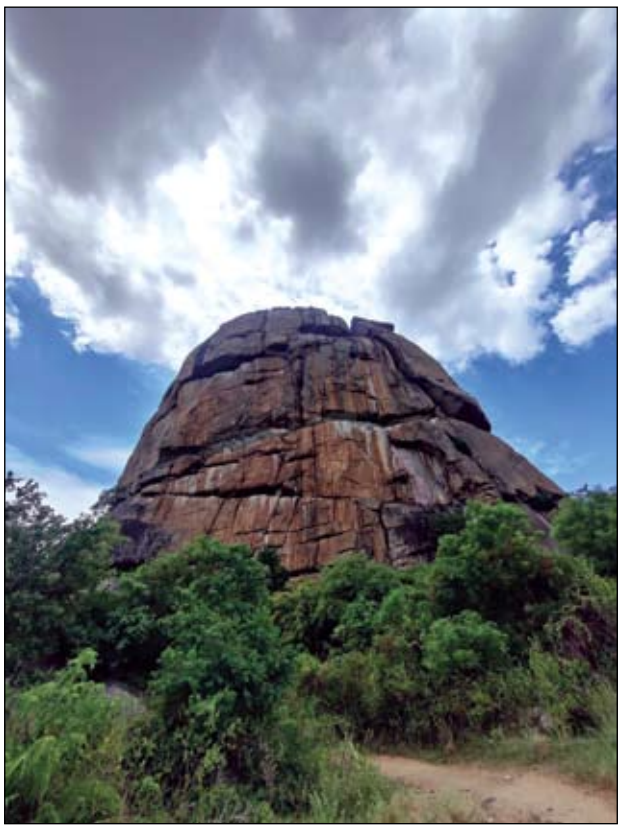
Bye bye Hives!
Giving better lives

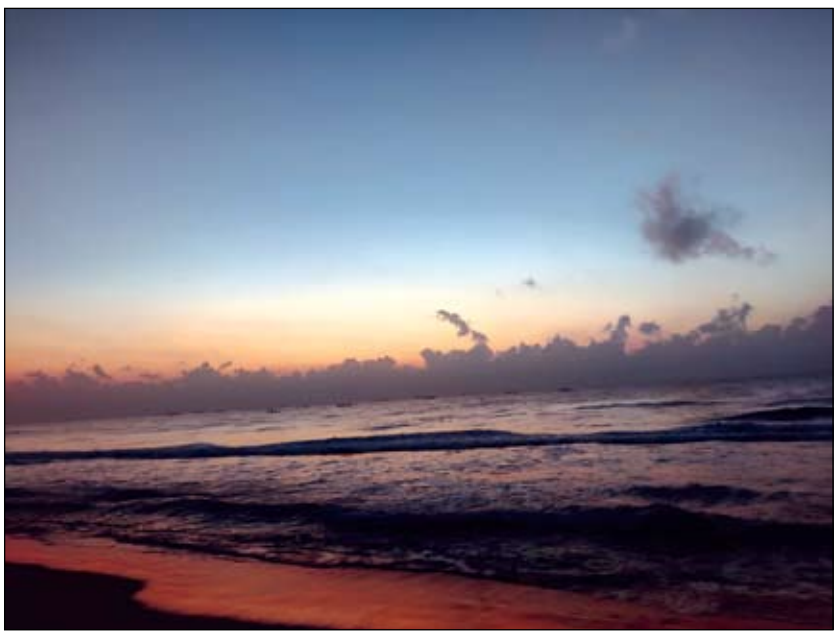
Ciao Tinea!
Dont give mania

Dr. Vyjayanthi
JR3, Akash Institute of
Medical Sciences and
Research Centre

Shutter stories: A collection of Photographs

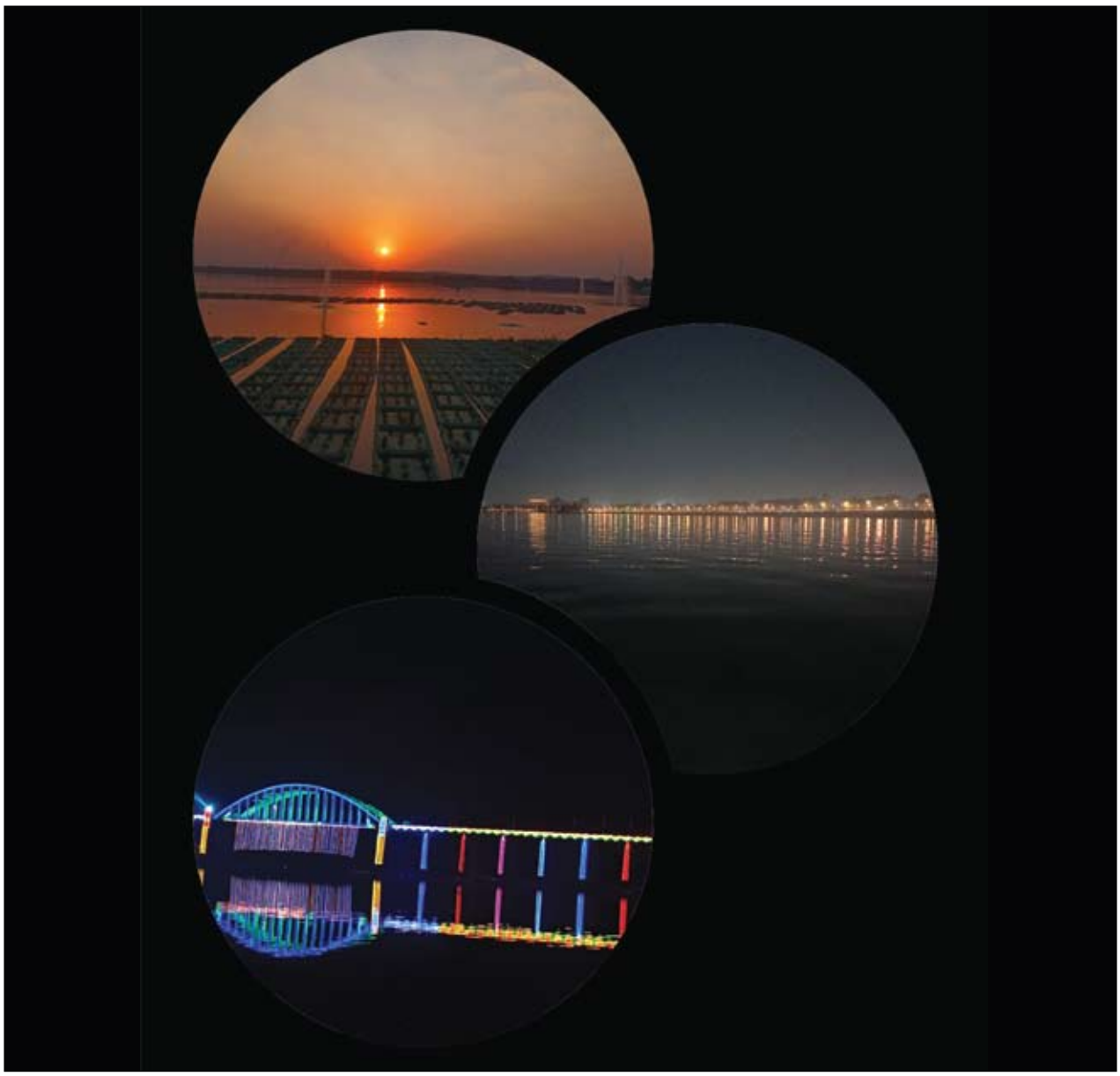
Dr. Kamlesh S Baldaniya





Dr. Chinni Sai Sahithi
Senior resident,
DVL Department,
Apollo Institute of Medical Sciences and Eesearch

Dr Sharavi B
Junior Resident,
Dept. of dermatology,
BGS GIMS, Bangalore



Reflections : In sun's warmth or moon's soft glow, Amidst the lights or human flow, I, the water, mirror you, Your joyous smiles, your tears that race, In my depths, they find their place. I reflect your joy, your sorrow's weight, The stories untold, the love innate, Amidst hills and valleys, I flow, Quenching thirst where'er I go, Like a river, ceaselessly run, Reflecting life 'neath the blazing sun.

- Dr. Tejaswini M

Dr. Tejaswini Anoop
2nd year PG
KIMS, Hubballi

Riddles

1. I'm not a sunburn, but I make skin flare,
   I'm not a bruise, but I'm not rare,
   With silvery scales, I can be quite a sight,
   What am I, causing skin to fight?
   Psoriasis
2. I'm not a wound, but I cause skin to weep,
   Like a relentless enemy, I don't let up
   or sleep. Desmoglein proteins, under
   attack they fall, What am I, causing skin's
   downfall?
   Pemphigus
3. I'm not a stain, but I change skin's tone,
   Patches of white, where pigments have
   flown.
   Autoimmune in nature, I play my role,
   What am I, affecting skin's whole?
   Vitiligo
4. I'm not a simple scratch, but I cause much
   pain, Skin so fragile, it tears like paper in
   the rain. Blistering and tearing, with the
   slightest touch, What am I, making skin's
   resilience clutch?
   Epidermolysis bullosa
5. I'm not a rash, but I spread beneath the
   skin, Painful lumps and bumps, where
   infection begins.
   Chronic and debilitating, I take my toll,
   What am I, beneath the skin's scroll?
   Hidradenitis Suppurativa
6. I'm not a critter, yet I make you itch,
   Tiny and sneaky, but easy to pitch.
   I spread in close contact, causing distress,
   On your skin, I'm not a welcomed guest.
   What am I?
   Scabies
7. I'm not fishy, nor am I scaly or wet,
   Yet on your skin, a peculiar set.
   Dry and rough, I make my mark,
   Inherited sometimes, leaving a spark.
   What am I?
   Ichthyosis
8. I'm not just thick, but my nails do show,
   A condition rare, a fact you may not know.
   Congenital in nature, I'm present from
   birth,My name's quite a mouthful, for all
   it's worth.
   What am I?
   Pachyonychia Congenita
9. II'm not a blush, but I paint your face
   red, A chronic condition that's often
   widespread. On cheeks and nose, my
   presence may show, Triggered by heat or
   emotions that flow.
   What am I?
   Rosacea
10. I'm not a ghost, but I make your skin tight,
    A condition rare, with symptoms that
    might Include hardened skin, and fingers
    that curl, Yet I affect more than just the
    dermal world.
    What am I?
    Scleroderma

Dr Rekha K
1st year PG Resident,
Karnataka Institution
of Medical Science,

EMBARKING ON A DERMATOLOGICAL ODYSSEY : MY JOURNEY THROUGH SKIN SCIENCE

At the very outset, I would like to take this opportunity to express my heartfelt gratitude to my teachers, seniors, co pgs, juniors, family and friends who have helped me secure the Gold Medal in Dermatology PG examination, 2023. Unlike other subjects like Medicine or Surgery which we focus on during our MBBS, we do not have much idea about Dermatology unfortunately which makes the subject challenging and fascinating at the same time. So I am happy to share my experience today and hope it helps my dear juniors to prepare for the big day - MD final examinations!

I. During the Post graduation period, it's crucial to focus on mastering the basics:

- Proper history taking and examination findings of the common OPD cases will benefit you for both theory and practical exams.
- Case based reading on a daily basis will help you remember better.
- Discuss important findings or rare cases that you come across with your colleagues/ seniors/ teachers, as the saying goes: "Eyes cannot see what the mind doesn't know!"
- Seminars, Presentations, journal Club might seem cumbersome but they are definitely worth the hassle. Since they are backed by references from multiple textbooks and articles, they are of great help especially for difficult topics and for recent advancements.
- It is practically impossible to be fully prepared for your exams and here I would like to stress on the importance of Mock examinations during PG period – it helps you learn time management, structured answer writing and understand the areas

needing more attention and time.

II. When it comes to Theory Exam:

- Stick to one standard textbook which you are comfortable with and avoid last-minute switches. Decide your resource early based on your comfort and understanding and do not panic if your friends aren't reading the same. Few topics might be better in other books which can be referred to if needed.
- Making notes on complex topics (especially for Paper 1) will save time later during revision and should be done during the early phase and not in the last few days before the exam.
- It is better to divide and read paper wise rather than randomly. Previous years question papers give you an idea about the pattern of questions asked and can guide you in your preparation.
- IJDVL resident pages and review articles are my personal favourites – they not only contain concise data compiled from multiple textbooks but also could be one of your bouncer questions in theory exams!
- Also know that not every day will be your best and that is completely fine. So do not feel guilty and waste more time, instead improve or compensate for it the next day.
- I would like to stress on the need for revisions – Dermatology being highly volatile, it is only normal to feel as if u don't remember/ recollect what you have read so minimum 3 readings are required.
- Do not hesitate to talk to your seniors/ colleagues/family or seek their advice if you are facing any difficulty or stress during this period.
- While writing the theory exams, systematic presentation of your answers with headings and subheadings and neat, labelled simple diagrams and flowcharts are at most important – they help you save time, impress the evaluator and fetch those extra marks!
- Never leave any question unattempted – try to write whatever you know about the topic. These bouncer questions require more time for you to think and answer so manage time accordingly and do not spend hours answering the questions that you know better.

III. A few tips for practical exams:

- Be well versed with the short and long cases – discuss and present as many cases as possible during your PG days. This will help you present efficiently and boost your confidence.
- Don't be tensed. Answer with confidence and humility, while maintaining respect for your examiners
- During the viva voce – begin by answering the common differentials first and lead the examiner towards the topics you know well.

These are few of the invaluable tips which helped me ace the exams. Reflecting on my journey, it was definitely not an easy one especially with the COVID pandemic at its peak. I am extremely honored to have achieved this milestone. So I would like to conclude by saying trust the process and believe in God Almighty and you will reap the seeds of success through hard work and perseverance. All the best!

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We hope you have liked this effort of ours.

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Regards,

Editorial Team