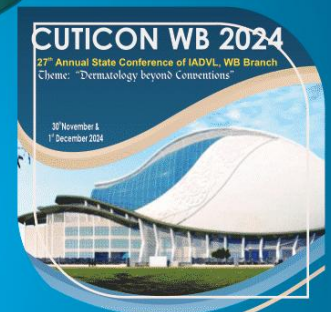




Indian Association of Dermatologists, Venereologists & Leprologists West Bengal State Branch

SKINTELLECT

The Official Newsletter of the IADVL West Bengal State Branch



Issue Spotlight

- 🔪 Abhaya: A wakeup call
- 🔪 Dermatologist Spotlight: Dr. Saumya Panda
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- 🔪 Resident Corner: Pediatric Pigmentary Dermatoses

"Skintellect," is the online monthly newsletter of the IADVL WB, dedicated to the dynamic world of dermatology. This publication is a testament to the commitment of our members towards advancing the ever stretching horizon of the discipline, sharing knowledge, creating bonhomie and archiving our IADVL WB activities.

Volume 2, Issue 5, September 2024



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Secretary's Scribes

Dear Esteemed Members of IADVL,

I extend my monsoon greetings to you.

I would like to convey my sincere gratitude for your commitment to our association and your support.. in the first half of this month, 10th and 11th August, Central Council Midderma Meet 24 happened at IADVL HQ. Working President Dr Nilendu Sarma, Hony Secretary D Suchibrata Das, CC member Dr Kingshuk Chatterjee, Dermacon 2026 Bidding Committee Member Dr Sandipan Dhar, Dr Sudip Das, Presidential Candidate Dr Koushik Lahiri were among our members attended the meet. Twenty five proposals including, Organization of PEDDERMACON Biennial conference by bidding similar to DERMACON, To cut down the MIDDERMACON down to two days, Honorary Secretary General (HSG) should be included as a member in all IADVL selection committees and as a jury in awards selection along with President, President elect and immediate past president, etc. were discussed in the meet. Details of that are available in the IADVL NEWS_Aug2024_web_v19.

We are excited to announce that preparations for the Digital International Conference Biswaderma and our annual Cuticon WB 2024 are in full swing. Our dedicated, experienced, and hardworking organizing committee members are working tirelessly to ensure these conferences are a grand success.

We are committed to continuing our community health and academic programs as scheduled. While some unavoidable delays have occurred, we are making every effort to maintain the continuity and quality of these important initiatives.

Long Live IADVL!

Warm Regards,



*Dr. Suchibrata Das
Honorary Secretary
IADVL WB*



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Editors Desk

Dear Members,

The month of August has been challenging for all of us, particularly due to the tragic incident involving our colleague at RGKAR Medical College and Hospital. In light of this, we present a special article by Dr. Bartika Sikder, on behalf of the Editorial Board, reflecting on workplace safety for women. We hope that this article fosters discussion and leads to the implementation of stringent safety norms soon.

In our Spotlight Column, we feature Senior Consultant Dermatologist, Dr. Saumya Panda, who shares his insightful journey and invites everyone to attend 'Biswaderma', an international webinar being organised by our state branch where he serves as the Scientific Chairperson.

Our Dermbuzz column provides the latest updates on chronic prurigo, and our Resident Corner features an informative article on pediatric pigmentary dermatoses.

We hope you enjoy this edition.

Warm Regards,



Dr. Shreya Poddar
Editor, Skintellect,
The IADVL WB Monthly Newsletter
Hony. Joint Secretary, IADVL WB

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DERMATOLOGIST SPOTLIGHT: Dr. SAUMYA PANDA

1. *It is an honour to interview an academic stalwart like you Sir. You have been the editor of multiple esteemed journals in your career. What drives or motivates you to pursue academics and research work alongside clinical practice?*

It is difficult to explain the source of such motivation, other than an esoteric love for academic pursuits. I call such an impulse inexplicable otherwise because in the system that we operate as clinical practitioners in this country, there is hardly any scope of positive reinforcement to facilitate such activities. It is really strenuous logistically for a private practitioner to undertake serious research in the clinical field. Even keeping oneself updated by studying current literature takes a toll on the single most important saleable resource that a young practitioner possesses – time.

I consider myself fortunate to have been able to publish original research articles regularly in those initial years when I was purely in solo private practice, including in top notch journals like the BJD, Contact Dermatitis, Archives of Dermatology (currently JAMA Dermatology), JAAD etc other than in the IJD and IJDVL. Certainly, the modest success in publication spurred me on doing more of the same in the years to come.

Research and publication are always a group activity. Thus, it would be amiss if I did not acknowledge my senior collaborators of those fledgling years - Dr Subrata Malakar, Prof Debabrata Bandyopadhyay and Dr Koushik Lahiri being prominent among them. Perhaps my career would have taken a completely different, and entirely casual turn, if I did not have their company in those crucial years. No doubt that the encouragement and inspiration that I drew from my early collaborators went a long way in shaping the trajectory of my academic career.

Finally, I must mention Prof Sujit Ranjan Sengupta, the then Editor of IJD, who brought me in the Editorial Board of the journal within two years of starting my career as a dermatologist, which provided the insight and impetus to engage myself in the two most underrated yet immensely important domains of scientific gatekeeping, namely reviewing and editing.

2. *What would you say is your biggest contribution to the journals you have been associated with as editor and what sort of change do you wish to see in the coming future in the way research is done and published, especially in India compared to the international forum?*

It is difficult for me to evaluate my own contributions as an editor in an objective manner. During the decade that I could contribute meaningfully to the IJD as an Executive Editor (2006-15), I learnt a lot from the two editors, Dr Sandipan Dhar and Dr Koushik Lahiri, particularly the values of teambuilding, working as a team and always keeping the interest of the journal ahead of one's own. On the other hand, I am obliged to Prof Debabrata Bandyopadhyay for sensitizing me to the scientific nuances of editing and reviewing, and giving me a nudge to develop my interest and understanding of the domain of evidence-based medicine, without which no editor of a modern scientific journal can contribute significantly in this job. During my tenure, we had the privilege of witnessing the re-indexing of IJD, the oldest indexed Asian dermatology journal, in the database of NLM. Personally, maybe I had a small role to play in conceiving and curating the Symposium series of articles, which subsequently garnered a handsome number of citations. Later on, I would embark on editing an 11-part module on research methodology and biostatistics in the journal, an exceptionally sustained and exhaustive discussion on research design and analysis in a dermatology journal, that certainly brought attention and respect to the journal among the research community.

In IJDVL, where too I had a longish tenure of more than six years (seven, including the term as the Editor-Elect), I





would like to be remembered as an uncompromisingly impartial editor, who stood for the virtues of open-mindedness and intellectual honesty, who gave no favours, and consequently had no (well, actually, very few friends. With the help of a pan-Indian editorial team that we built and nurtured, IJDVL had developed a redoubtable (or, notorious, depending upon where you stood multilayered editorial and reviewing process matched by only a few journals in the world. I take some pride, in retrospect, that we could maintain the functional integrity even during the bleak pandemic years (2020-22), that tested the editorial prowess of even the very big journals across the world.

Based on my experiences as an editor, I would say that we in India are, generally speaking, still far behind in research and publication skills, even in dermatology, which is one of the front-ranking disciplines among the biomedical sciences in this country. IJDVL, by the way, was the highest ranked scholarly journal published from India across all disciplines (all sciences including biomedical and health sciences, physical sciences and mathematics, technology and engineering, social sciences and the arts and humanities), as per the JIF, for four years (2017–20), a position that it has again retained in the biomedical sciences category this year. The overall grasp of the clinicians and researchers in their communication abilities still leaves a lot to be desired. Though the situation has improved quite appreciably over the past decade or so, there is still a palpable lack of adequate understanding of the finer nuances of modern research methodology and basic biostatistics even among a significant proportion of senior researchers and faculty. Thus, despite a wealth of significant clinical data, authors from India face rejections in competitive clinical journals from the West and even in our own top-rated journals. At the same time, journals from India face the dilemma of whether to retain articles based on novel, relevant and interesting clinical facts, or to reject the same due to poor writing or reporting quality. This further results in long delays in manuscript processing, prolonged article turnover time and tardy final decisions. At the same time, established and prestigious society-based journals struggle to improve the quality of poorly written content from the contributors. All these situations directly and indirectly negatively impact our journals' growth as well as the growth of individual authors. The only recourse to come out of this vicious cycle lies in the hands of public policymakers, who can take a cue from China, a country that lagged behind India even 20 years back in research and publication. Due to well-conceived policies that promoted indigenous research, the latter has not only gone way ahead of us, but are frontrunners in many disciplines at a global level.

3. Sir, you are the head of department in JIMS currently, as a teacher what would your advice be to the young dermatologists about the changing trends in clinical practice and dermatosurgery?

There is no doubt that these days any newcomer in the field of dermatology practice has a much more arduous journey in front of her/him than in our time. The quantum of competition as also its quality has changed tremendously. As the head of the department, one question that I ask invariably to any newcomer Resident is: "Why have you chosen dermatology"? Unfortunately, quite a few times, if the answer is candid, they are here for some very wrong reasons, like the popularity (and "lucrative returns") of cosmetic dermatology, lasers and so on and so forth. If the older characterization of dermatologists as the purveyors of lotions and potions was entirely inappropriate, so too is the current obsession with fillers, lasers, peels and the like, as if these are the be-all and end-all of modern dermatology. Make no mistake: All these have their roles in dermatology management, and these are here to stay. However, beneath the veneer of the new-found glamour, dermatology stubbornly remains a quintessentially clinical discipline, where the clinical practice, for a large part, has to be customized on almost an individual basis. There are reasons why there is a paucity of universally accepted guidelines beyond four or five clinical entities in dermatology, in contrast to several other branches of medicine: the enormous diversity in clinical presentations that is largely due to the mind-boggling level of connections of skin with the immune system as well as the organs beneath. That makes dermatology the queen



of clinical sciences, where the clinical acumen of practitioners reigns supreme over the humdrum routine of guidelines for a major part and, where the heuristic of diagnostics and management is not subsumed by, but rather an ally of, evidence-based practice. Thus, any new entrant who can get a sense of the discipline in these terms will, depending on her or his inclination, come to terms with the enormity of clinical dermatology or the intricacy of core dermatosurgery (which, by the way, is as different from the much more superficial aspects of cosmetic dermatology as chalk is from cheese). As teachers, I think we have a duty to try and familiarize our students in these terms to our discipline. Once this sense and wonder of the subject is instilled in them, in my humble opinion, any newcomer will find it much easier to navigate even the choppy waters of the market of dermatology practice than the numerous others who are deluded with the false mirage of glamour (sorry for the countless mixed metaphors).

4. *On a lighter note, what are your hobbies and interests Sir? How do you manage your family time along with work?*

Well, I have been a voracious reader from my childhood, thanks a large extent to my father's very well-stocked library. Books have been my favourite friends during the years when I grew up as a lonely introvert boy right up to these days. (As a corollary, writing also became my hobby those days.) Only, as time has passed, my tastes have become more eclectic, ranging from scholarly journals to pulp fiction. But I do not think that I have ever passed a day without reading anything.

During my days in the Medical College hostel, I stumbled upon another of my hobbies – cinema. Someone told me that the British Council Library (BCL) membership entitles one to regular shows of the best in the British cinema. Those days, I would frequent BCL, the American University Center (AUC, where one of my father's friends was one of the honchos) and much later, Nandan, as my taste was pretty high brow. These days, I find that the habit dies hard, though I have become accustomed to viewing the trash with the good and seem to enjoy both!

I think that you should better ask my family the second question. Two things have helped: my wife seemed to have given up on me pretty long time back, and does not nag me any more for giving time. My daughter, who is now a big girl, being in the final year of her MBBS course, thankfully has always been much more serious in her studies than I have ever been, and did not seem to have bothered too much about my being around her, or not. My son, much younger and in the terrible teens, is a different proposition, however. For as long as I remember, his interests in life change more radically and faster than time itself. It seems yesterday when his goal was to be a master in chess. So, it fell upon me to teach the game. Now when for the last three years or so, I have not been able to last more than 30 moves against him, and he gradually lost interest in playing against me, I heaved a sigh of relief. Now, suddenly comes the Olympics, and Lakshya Sen, and now, who else, but again I have to wield the racket after nearly half a century and start giving him badminton practice! Phew! It's really no joke being a father!

5. *Concluding the interview with one last question Sir, it is a matter of immense pride that IADVL WB is organising the Biswaderma Conference and you are the Scientific Chairperson which is to be attended by 26 international delegates. Can you please tell us a little bit about this endeavour and what these sessions have for dermatologists to look forward to?*

Biswa Derma, which literally means 'Bengal Dermatology Beckons the World', is a virtual global dermatology conference. In terms of conceptualization and ambition, it is the first of its kind in Indian dermatology. It boasts of 26 international faculty, who are just not international in terms of their location, but certainly global in terms of their stature and accomplishment. Such a huge constellation of academic giants is an unheard-of



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phenomenon in Indian dermatology.

Ranging from an almost philosophical, sage-like exposition of the principles of dermatological diagnosis by Hywel Williams and a detailed deliberation on nonbullous pemphigoid by Barbara Horvath to the discussion of limits of Mohs micrographic surgery in nonmelanoma skin cancer by Jorge Ocampo-Candiani and the recent concepts and applications on prevention of atopic dermatitis by Alan Irvine, the scientific program encompasses literally the veritable length and breadth of our discipline. Each session, of a uniform one-hour duration, will consist of two pre-recorded lectures followed by live panel discussions conducted by as many as 60 moderators and panelists drawn from the glitterati of our specialty all over our country.

21st and 22nd September are going to be red letter days in the annals of Indian dermatology and I, as the Scientific Chairman, welcome you all to savor first hand this historic occasion.





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Details of one time Admission fees

The Admission Fees payable shall be based on age in years of the proposed member or their family member who likes to join the scheme, as follows :

No.	Age	Rate in Rs.
1	Up to the age of 10 Year	1,000
2	11 of 20 Years	1500
3	21 of 30 Years	2000
4	31 of 40 Years	3000
5	41 of 50 Years	4000
6	51 of 60 Years	5000
7	61 of 70 Years	7000
8	Above 70 Years	8000

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- Fraternity contribution Rs. 500 x N, where N = No. of Death of members)

Plus, Optional professional indemnity annual legal fees, to be paid by those members who opt for professional indemnity.

DERM BUZZ : UPDATES IN THE PATHOGENESIS AND MANAGEMENT OF CHRONIC PRURIGO

Dr. Deblina Bhunia

Associate Professor, Department of DVL,
M.G.M. Medical College, Kishanganj, Bihar

Chronic prurigo (CPG) is a neuroinflammatory dermatosis and it is characterized by chronic pruritus (>6 weeks), scratch-associated pruriginous skin lesions with history of repeated scratching.

Several sub-entities have been described according to the type of pruriginous lesions. The umbrella term of CPG can be used instead of defining the subtypes. Among the subtypes Chronic prurigo of nodular type (CNPG; synonym: prurigo nodularis) is the commonest.

Pathogenesis:

Neuronal sensitization to itch followed by the development of an itch-scratch cycle is thought to be the main pathomechanism. CNPG is linked to atopy in a subset of patients. Several cell types including keratinocytes, mast cells, inflammatory cells (lymphocytes, eosinophils), nerve fibres, dermal vessels, and fibroblasts are involved in the pathophysiology. The dermal inflammatory infiltrate of CNPG consists of mainly T lymphocytes, as well as increased numbers of 2D7+ basophils and major basic protein+ eosinophils. These dermal cells express IL-4, IL-13 or IL-31 to a higher level than the non-lesional skin. Dermal substance P + nerve fibres also play role in proinflammatory signaling resulting in the release of neurotrophic factors.

Clinical features:

All age groups can be affected by CPG, although elderly people are more frequently affected. Pruriginous lesions of CPG can be divided into papules, nodules, plaques and umbilicated papules/nodules or linear lesions. Multiple types of lesions may coexist. Lesions can be localized or generalized.

CNPG is characterized by severe and persistent pruritus. The intensity of pruritus doesn't depend on the patient's age and sex and the possible presence of atopy. A vast majority of patients experience sleep disturbances due to pruritus. Patients with CPG experience a significant psychological burden and impairment in quality of life.

Examination and investigations:

The diagnosis of CPG is usually made clinically. But, the origin of chronic pruritus should be identified. A comprehensive medical history, including itch-specific details (e.g., onset and intensity of itch), assessment of medications, comorbidities and psychiatric history should be obtained.

The distribution and type of lesions are determined by physical examination.

The severity of CNPG can be assessed by the number of lesions and also by validated clinician-reported outcome tools such as the Prurigo Activity and Severity (PAS) score and Investigators Global Assessments (IGA) for chronic prurigo. A thorough mucocutaneous and systemic examination including palpation of the abdomen and lymph nodes should be performed to identify associated skin/systemic disease.

To further investigate the potential underlying etiology, laboratory workup is required including a blood count, with a differential count, CRP, liver and renal function test, LDH, and TSH. Additional tests should be considered based on the history and examination findings. Chest radiography, lymph node and abdominal sonography are recommended to rule out malignancy in suspected cases.

Although CNPG is primarily diagnosed clinically, histopathology and immunofluorescence can be beneficial in doubtful cases and to rule out other mimickers like bullous pemphigoid and lichen planus. The common histopathological features of CNPG are epidermal acanthosis, dermal fibrosis with a dense inflammatory infiltrate.

Therapies:

In addition to emollients the following therapeutic options CNPG are available:

(I) Topical therapies:

- Topical anti-inflammatory therapies - topical /IL corticosteroids, topical calcineurin inhibitors [TCI] (e.g.: tacrolimus, pimecrolimus).





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- Topical analgesics - anesthetics, capsaicin.
- Topical antiproliferative agents - coal tar, vitamin D derivatives (calcipotriene).
- (ii) Ultraviolet phototherapy- NBUBV, PUVA and laser (excimer).
- (iii) Systemic therapies:
 - Antihistamines
 - Immunosuppressants / immunomodulators- corticosteroids, cyclosporine, methotrexate, azathioprine, thalidomide/lenalidomide.
 - Neuromodulating therapies - opioid modulators (e.g.: naloxone, naltrexone etc.), neurokinin-1 receptor antagonists (e.g.: aprepitant), antidepressants (e.g.: paroxetine, fluvoxamine et.), gabapentinoids.
 - Immunomodulating therapies - biologics (dupilumab, nemolizumab) and oral JAK inhibitors.

Recently, dupilumab (IL-4,13 inhibitor) and nemolizumab (IL-31 inhibitor) have been approved by FDA as systemic treatment for adult patients with CNPG.

Drugs under investigations:

- i) Agents targeting opioid receptors: nalbuphine, a κ -opioid receptor agonist and μ -opioid receptor antagonist.
- ii) Agents Targeting IL-31 Receptor A/ Oncostatin M Receptor β : vixarelimab
- iii) Topical and systemic JAK inhibitors: ruxolitinib, abrocitinib, povorcitinib
- iv) Inhibitor of KIT activation: barzolvolimab

The current International Forum for the Study of Itch (IFSI) guideline on chronic prurigo recommends following step-by-step approach:

Step 1: TCS, TCI and H1 antihistamines;

Step 2: Topical capsaicin, IL corticosteroids and UV therapy;

Step 3: Gabapentin, pregabalin or antidepressants in case of predominating neuropathic characteristics vs cyclosporine/methotrexate in case of predominant inflammation;

Step 4: NK1R antagonist, μ -opioid receptor antagonists, dupilumab, nemolizumab, thalidomide.

DERMACON INTERNATIONAL 2027
55th National Conference of IADVL

We request you to bless KOLKATA as venue for
DERMACON International 2027

RESIDENT'S CORNER: PEDIATRIC PIGMENTARY DERMATOSES: A SHORT OVERVIEW

Dr. Sharmistha Panja

2nd year PGT, R G Kar Medical College

Skin pigmentation normally varies according to the racial origin and the amount of sun exposure. Certain disorders of hyper- and hypopigmentation are more common in children. It is imperative that practitioners can swiftly and accurately diagnose these pigmentary disorders to prevent treatment delays and enhance the quality of life. Pigmentary disorders with varied etiologies may present with similar clinical features. However, treatment varies widely and is dependent on accurate diagnosis. Herein, an overview of common pigmentation disorders in children with skin of color is briefly discussed that may present as an isolated finding, a manifestation of an underlying systemic disease, or as an association of a syndrome. The following are the various etiologies of pigmentation disorders:



Etiologies of hypopigmentation disorders:

A. Generalised:

I. Genetic:

- **Oculocutaneous albinism:**
 - ✓ Defect in melanin production: OCA 1-4, Prader Willi, Angelman syndrome
 - ✓ Defect in the packaging of melanosomes: Hermansky Pudlak, Chediak Higashi
 - ✓ Unknown mechanism: CROSS syndrome
- **Inborn errors of metabolism:** Phenylketonuria, Homocystinuria, Histidinemia
- **Genodermatoses:** Griscelli syndrome, Menkes syndrome, EEC (Ectrodactyly-ectodermal dysplasia-cleft) syndrome

II. Autoimmune: Vitiligo universalis

III. Nutritional deficiency: Selenium, copper

B. Localised:

I. Depigmentation:

- Vitiligo
- Piebaldism
- Wolfsyndrome
- Waardenberg syndrome
- Tietz syndrome
- Post-inflammatory depigmentation

II. Hypopigmentation:

- **Congenital:** Nevus anemicus, Nevus depigmentosus, Pigmentary mosaicism with hypopigmentation, Ash leaf macules in Tuberous Sclerosis, Fanconi syndrome
- **Acquired:**
 1. **Post-inflammatory** (in pityriasis lichenoides chronica, pityriasis rosea, burn, trauma, lichen striatus, post-infection, pityriasis alba)
 2. **Inflammatory:** Lichen sclerosus, morphea, mycosis fungoides, psoriasis, seborrheic dermatitis
 3. **Infections:** Post Kala Azar dermal leishmaniasis, pityriasis versicolor, Leprosy, Yaws, Onchocerciasis
 4. **Autoimmune:** Lupus erythematosus, sarcoidosis
 5. **Drugs and Chemicals:** Corticosteroids, Hydroquinone, Arsenicals, antimalarials

Etiologies of hyperpigmentation disorders:



1. **Diffuse:** Carbon baby syndrome, Addison's disease, Vitamin B12 deficiency
2. **Localised:**
 - ✓ **Genetic:**
 - *Lentigens*
 - *Freckles*
 - *Incontinentia pigmenti*
 - *Pigmentary mosaicism with hyperpigmentation*
 - *Peutz Jeghers syndrome*
 - *Fanconis anemia*
 - *Dermal melanocytosis*
 - *Melanocytic nevi*
 - *Dyschromatosis symmetric hereditaria*
 - *Becker's Nevus*
 - *Cafe au lait macules*
 - *Urticaria pigmentosa*
 - *Watson syndrome*
 - *NAME syndrome*
 - *Phacomatosis pigmento vascularis*
 - *Xeroderma pigmentosum*
 - *LEOPARD syndrome*
 - *McCune-Albright syndrome*
 - ✓ **Metabolic:** *Porphyria, Gaucher's disease, Niemann-Pick disease, Wilson's disease, Acanthosis nigricans*
 - ✓ **Endocrine:** *ACTH therapy or tumors, Addison's disease*
 - ✓ **Nutritional:** *Pellagra, Vitamin B12 deficiency, Kwashiorkor*
 - ✓ **Chemicals and drugs:** *Bleomycin, Busulfan, Cyclophosphamide, Arsenicals, 5-Fluorouracil, nitrogen mustard*
 - ✓ **Physical:** *Burns, Ultraviolet and ionizing radiation*
 - ✓ **Inflammatory:** *Lichen planus, morphea, postinflammatory*

Approach: A detailed history, meticulous clinical examination, and appropriate investigations are the cornerstones in the diagnosis of dyspigmentation in children. The suspected diagnoses guide the investigations. A detailed history regarding the lesions' onset and progression, family history, and a thorough clinical examination are needed. Bedside tests like Wood's Lamp and dermoscopy are invaluable in diagnosis of these disorders. Wood's Lamp is an inexpensive tool to help diagnose superficial infections and pigmentary disorders, for example, it can differentiate hypopigmented pityriasis versicolor and vitiligo. Dermoscopy is a non-invasive diagnostic modality with great potential in the diagnosis, prognosis, and follow-up of pigmentation disorders. Dermoscopy can help identify and differentiate melanocytic from dysplastic pigmented lesions, evaluate vitiligo activity, and also differentiate vitiligo from other hypopigmentation disorders. Ophthalmological examinations like funduscopy and slit lamp examination may be helpful in diagnosis.

Relevant investigations like peripheral blood smear, endocrinological evaluation urine analysis, KOH mount, skin biopsy, MRI brain, Electrocardiogram, Echocardiography, and gastrointestinal endoscopy, guide us to reach the diagnosis. For congenital hypo and hyperpigmented disorders, karyotyping and molecular genetic analysis of the skin and blood may be considered, especially if the child shows developmental or structural abnormalities.

Management:



Effective management of pigmentation disorders often involves a multidisciplinary approach involving cooperation and regular communication between dermatologists, pediatricians, child psychiatrists, counselors, and other specialists as certain disorders may involve other systems as part of a syndromic association or it may be a manifestation of internal disease and also involves the management of psychological distress of the children. Treatment of the underlying condition resulting in the pigmentation disorder is essential, especially in inflammatory and infectious causes. Some specific measures are as follows:

For hypopigmentation: *In general, treatment options for many hypopigmented disorders, particularly those that are congenital in origin, are limited.*

- *For hypopigmented diseases with an associated inflammatory component, treatment may involve the use of topical corticosteroids and calcineurin inhibitors for localized lesions, and phototherapy for widespread lesions, especially in older children.*
- *Autologous grafting of cultured and non-cultured melanocytes has been successfully used to treat stable vitiligo and piebaldism.*
- *Sun protection, including the use of broad-spectrum sunscreen on hypopigmented lesions as these lesions are more vulnerable to sun damage*
- *Cosmetic cover-ups including topical stains and tanning products containing dihydroxyacetone can be used to reduce the color contrast between the lesions and normal skin.*

For hyperpigmentation:

- *Mild topical corticosteroids may be of benefit in some cases.*
- *Sun protection may be in the form of broad-spectrum sunscreen, hats, or sun-protective clothing. Encouraging children to avoid excessive sun exposure, especially during peak hours, can help manage hyperpigmentation.*
- *Mild chemical peels, such as those containing glycolic acid, can be used to exfoliate the skin and reduce pigmentation, though this treatment should be used cautiously in children.*
- *In some cases, lasers such as Q-switched lasers may be used to reduce pigmentation, though this is typically reserved for older children or those with significant hyperpigmentation. Intense Pulsed Light (IPL) is another option that can be used to treat certain types of hyperpigmentation.*

Conclusion: *Understanding pigmentary disorders is crucial for early diagnosis and management, as it can help mitigate potential complications and improve the quality of life for pediatric patients with pigmentary disorders.*



ABHAYA: A WAKE-UP CALL FOR WORKPLACE SECURITY IN THE MEDICAL FIELD

Dr. Bartika Sikder

Editorial Team, Skintellect

The day was 9th August 2024. While the nation draped itself in the tricolours of Independence, our medical fraternity was shaken to the core with the dreadful news of the death of one of our young members. A 31-year old lady doctor was brutally raped and killed while she was on a 36 hour duty in a renowned medical college in Kolkata. Over the next few days, as we struggled to come to terms with the inhumane nature of this atrocious crime, we were also forced to think about the reality of safety in our workplaces. In a study published in *Birdem Medical Journal 2020*, the Indian Medical Association suggested that upto 75% of doctors have faced some sort of workplace physical violence or even telephonic threats, intimidation and verbal abuse. Infact, this problem is quite prevalent throughout the world. In the UK, 52% of doctors have reported some kind of violence. More than 70% of doctors in Australia have also experienced workplace violence. There has been a constant increase in the incidence of violence against doctors in recent years, especially in India. Every few days news of one such particularly violent incident takes the social media by storm, and then dies down rather quickly, leaving us doctors to accept it as a professional hazard and resign to our fates. But what about the doctors who had to face such a situation? Some unfortunate souls get seriously injured, shot or even murdered, while others struggle with post traumatic stress disorder, depression, anxiety, insomnia or a tarnished reputation. Sadly, most of us doctors don't even know what constitutes aggressive behavior. This unfortunate incident has been a wake up call for not only doctors, but also professionals from other fields to speak up against workplace violence. On the eve of Independence Day, the entire nation came together to mourn their daughter, their "Abhaya". Rallies and demonstrations demanding strict punishment of the criminals flooded the streets, doctors put their pens down in respect, while administrators busied themselves in making new policies to ensure a safer working environment. "Abhaya" has united our nation in grief, and kickstarted a much needed conversation regarding the safety of women in our country as a whole. In the wake of such an unimaginable crime, we expect better security in hospitals of all tiers, proper training of all healthcare workers regarding patient handling and stringent laws against workplace violence.

Dear "Abhaya", we are sorry we couldn't provide a safe haven for you. We owe you for bringing us together as a nation and making us question the true meaning of "Independence" this Independence Day. We promise to bring you justice, and to make sure that no citizen of India ever has to face such a fate ever again, definitely not in their workplace. Rest in peace dear Doctor, you have taken a piece of our heart with you and left us with an irreplaceable void and a newfound conscience.



Quiz Zone

- 1 A 15-year-old male with mild intellectual impairment presents with multiple hyperpigmented lesions on the trunk and axillary freckling. Family history was positive for similar lesions in his mother. No ocular findings or cutaneous findings consistent with neurofibromas or plexiform neurofibromas were present. Genetic testing was negative for Neurofibromatosis Type 1. What gene mutation accounts for this patient's condition?

- A. PTPN11
- B. RET
- C. GNAS
- D. SPRED-1
- E. Merlin



- 2 Criteria for PHACE syndrome includes presence of a facial hemangioma >5cm + 1 major or 2 minor criteria. Which of the following is a major criterion of PHACE syndrome that could be used in combination with the large hemangioma to clinch the diagnosis?

- A. Intracranial hemangioma
- B. Ventricular septal defect
- C. Posterior segment ocular anomalies
- D. Anterior segment ocular anomalies
- E. Hypopituitarism

- 3 A 31-year-old male with history of recurrent febrile episodes presents with the following skin findings. The gene that is mutated in this condition encodes for what type of protein?

- A. Tyrosine kinase receptor
- B. Protein tyrosine protein phosphatase
- C. Telomerase complex
- D. DNA helicase
- E. Nuclear envelope protein



- 4 What should this patient be evaluated for?

- A. Deafness
- B. Cataracts
- C. Neurocutaneous melanosis
- D. Limb length discrepancy
- E. Brachydactyly



- 5 Hemangiomas of infancy are more likely to be:

- A. GLUT-1 negative
- B. Merosin positive but GLUT-1 negative
- C. Lewis Y antigen positive, merosin negative
- D. Glut-1 positive, merosin positive, Lewis Y antigen negative
- E. Glut-1 positive, merosin positive, Lewis Y antigen positive



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Volume 2, Issue 4 Answer:

Ans 1

- Confluent and reticulated papillomatosis (CRP)/Gougerot-Carteaud syndrome
- Dietziapapillomatosis, anaerobic gram-positive coccus/rod actinomycete.

Ans 2

- Human Protothecosis.
- Prototheca wickerhamii as the pathogen. Thereafter, oral Itraconazole (200 mg, twice daily) was prescribed and she was discharged with an improving wound. However, 4 months later, a second debridement was performed for recurrent Protothecosis. Her wound underwent much improvement with no residual redness or swelling after another 3 months.

Liao K, Fang C, Chen C. A red, swollen and painful lesion on the right hand after local steroid injections. Indian J Dermatol Venereol Leprol 2018;84:54-6.

Ans 3

- Chanarin Dorfman syndrome
- It is a multisystem, very rare, autosomal recessive lipid storage disorder, characterized by the accumulation of lipid vacuoles in neutrophils, and was first described by Dorfman in 1974.
- Due to a mutation in the ABHD5 gene of the short arm of chromosome 3, lipid is stored in the granulocytes at various sites in the human body, such as the muscle, liver, eye, ear, central nervous system, and bone marrow.
- Clinically, the disease is presented with ichthyosis, hearing loss, hepatomegaly, splenomegaly, cirrhosis, cataract, keratopathy, myopathy, and mental retardation.

Kalyon S, Gökden Y, Demirel N, Erden B, Türkyılmaz A. Chanarin-Dorfman syndrome. Turk J Gastroenterol 2019; 30: 105-8.

Ans 4

- Difelikefalin is a medication used to treat and manage uremic pruritis and postoperative pain, affecting patients' quality of life. Difelikefalin is in the opioid class of drugs and works as a selective kappa-opioid receptor agonist.
- Since difelikefalin is peripherally selective, it is unlikely to cause lethal central nervous system adverse effects such as respiratory depression. IV dosing schedule after dialysis sessions enhances treatment logistics and patient outcomes. Moreover, difelikefalin presents as a safer alternative for managing postoperative pain amid the opioid crisis, offering decreased abuse potential and promising results in early trials.

Ans 5

- Doxycycline
- Medication-induced esophageal injury is also known as pill esophagitis.
- The disruption of the esophageal mucosa occurs due to direct localized toxicity, generally caustic (acidic or alkaline) or hyperosmolar.
- Tetracyclines are the antibiotics that commonly cause pill esophagitis, with doxycycline being the most frequent.
- A surge in cases were seen during peak COVID 19 pandemic due to inadvertent use of doxycycline for COVID.
- Dysphagia or odynophagia with retrosternal pain were the main presenting symptoms and most commonly the injuries were observed at the middle third of esophagus with a normal surrounding mucosa.

The correct response given by

Dr. Debargha Mukherjee

Dr. Biswajoy Hore

Thank You for your answer and happy reading

Kindly send your entry to iadvlwb@gmail.com with 'Skintellect Quiz' as subject.

The correct response of each month gets acknowledged in the next issue.

Send your entries now!

Good luck from Team Skintellect.



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Indian Association of Dermatologists, Venereologists & Leprologists West Bengal State Branch



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Theme: "Dermatology beyond Conventions"

30th November
&
1st December 2024

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