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

SKINTELLECT

The Official Newsletter of the IADVL West Bengal State Branch

Issue Spotlight

"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 3, Issue 9, January 2026

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Note from the President

The month of December witnessed yet another meaningful academic engagement for our association. On 5th December, we successfully organised the Derma–Rheumat Interface at The Hotel Park, Kolkata—a programme that truly reflected the growing importance of interdisciplinary collaboration in modern dermatology.

The scientific content was meticulously curated by Prof. Sudip Ghosh, and we were privileged to have three eminent rheumatologists of our city—Dr. Prodyut Sinhamahapatra, Dr. Kaushik Basu, and Dr. Arghya Chattopadhyay—who enriched the deliberations with their vast clinical experience and practical insights.

The panel discussion saw a healthy mix of young and senior dermatologists, making the exchange of ideas both vibrant and balanced. The enthusiastic participation of the audience further contributed to the success of the programme, reaffirming the academic curiosity and engagement of our members.

Looking ahead, on 18th January 2026, we plan to organise a members' picnic, an occasion meant to strengthen camaraderie beyond academics. I sincerely look forward to the participation of a large number of our members and their families, making it a memorable and joyful gathering.

As always, I thank each one of you for your continued support and involvement in our activities. Together, we continue to learn, grow, and celebrate the spirit of our dermatology fraternity.

Warm regards,

Dr. Dinesh Kr. Hawelia
President
IADVL WB

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Secretary's Scribes

Dear Esteemed Members,

I take this opportunity to extend a belated Merry Christmas and convey my best wishes for a Happy, Healthy, and Prosperous New Year in advance to you and your families.

As usual , The month of December also has been academically vibrant and fulfilling for our chapter. We successfully conducted the Dermatology–Rheumatology CME, which was met with grand success and enthusiastic participation.

We also organized our regular Clinical Meeting at Kolkata National Medical College, which was graced by expert and erudite senior faculty members. Their active participation, insightful inputs, and guidance made the session highly enriching and memorable.

As we move into the new year, we have exciting activities lined up. We are going to conduct CHALO PATHSHAAL on 8th January, followed by the much-awaited IADVL WB Picnic on 18th January. I sincerely request all members to join, participate wholeheartedly, and be a part of the sensation that defines our vibrant association.

Looking forward to your continued support and active involvement in all activities.

With warm regards,

Dr. Suchibrata Das
Honorary Secretary
IADVL WB

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Editors Desk

Dear Readers,

The month of December has been academically enriching and eventful. A major highlight was the first interdisciplinary CME, "Derma–Rheumat Interface," held at Park Hotel, Kolkata, which witnessed vibrant and meaningful academic exchanges on key autoimmune diseases by eminent dermatologists and rheumatologists.

This month, our spotlight shines on Dr. Nitindramohan Mukherjee, who shares valuable insights from his long and fulfilling journey in the ever-evolving field of dermatology.

In the DermBuzz section, Dr. Srutee Barman discusses important considerations of laser therapies in skin of color, while Dr. Debalina Santra elaborates on the utility and expanding role of phototherapy in dermatology. Marking World AIDS Day on December 1st, Dr. Shatanik Bhattacharya highlights the significance of AIDS awareness in dermatological practice.

Dermaginations features a beautiful Bengali poem by Dr. Malay Sankar Mondal, adding a creative and cultural touch to this issue.

As the year draws to a close, beat the winter chill with our engaging Brainstorm section, and look forward to the much-awaited IADVL WB Picnic scheduled for January 18th.

We wish all our readers a very happy, healthy, and prosperous New Year ahead.

Cheers!

Happy Reading!

Dr. Kaushiki Hajra
Editor, Skintellect,
The IADVL WB Monthly Newsletter

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DERMATOLOGIST SPOTLIGHT: DR. NITINDRAMOHAN MUKHERJEE

Q1. Sir, what motivated you to choose dermatology, and how was your journey over decades?

A: To be honest, during my time there were very few MD seats available. I chose a subject where at least I could pursue a diploma. Another important reason was the advice of my very close friend, Dr Arup Moitra, who sadly passed away a year ago. He encouraged me to join dermatology, and that decision shaped my entire professional journey.

Q2. You are known for your strong focus on clinical dermatology and common skin disorders. How has your diagnostic approach evolved over the years, especially in the era of advanced investigations? What is your opinion on newer therapies and energy-based devices?

A: In our time, advanced investigations were not available; even biopsies were done very sparingly. My teachers—Dr R K Panja, Dr S K Panja, and Prof B Halder—were outstanding clinicians. They taught us that what the mind does not know, the eyes cannot see. We were trained to ask detailed questions about symptoms, family history, and disease course, and through careful observation and trial-and-error, we reached diagnoses.With time and by seeing a large number of patients, clinical understanding improves. Although many new investigations and technologies are now available, it becomes difficult with age to continuously learn and incorporate all new techniques because of lack of time, energy, and busy practice. Technologies like lasers and peels have their place, but I prefer medications as first-line therapy. Procedures should be used judiciously, not merely for financial gain.

Q3. In your experience, which common dermatological problems are often underestimated but significantly affect quality of life?

A: There are many such conditions. Eczema is often ignored initially, but once it becomes extensive, it severely affects quality of life. Similarly, conditions like tinea unguium and corns are neglected in the early stages. Interestingly, diseases associated with social stigma tend to be addressed earlier and more carefully by patients.

Q4. What is your opinion on the importance of bedside clinical examination today, and how can young dermatologists improve this skill?

A: Bedside clinical examination is irreplaceable. Recently, I saw a patient with verruca plana on the sole who was treated only based on photographs with 12% salicylic acid, without response. This highlights the problem of treating patients without proper examination. Online consultations can never replace bedside examination. Young dermatologists can sharpen this skill only by seeing patients regularly and gaining experience.

Q5. Looking back, which personal or clinical achievement gives you the greatest satisfaction?

A: It is always gratifying when patients tell me they have been cured. However, the greatest satisfaction is when a former patient brings their children or even grandchildren to me decades later, remembering that they were once successfully treated by me.

Q6. If you could change one aspect of dermatology training or practice in India, what would it be and why?

A: I can speak mainly about West Bengal. I feel cosmetology and dermatosurgery should be given much more importance and taught thoroughly during postgraduate training. One should not practice dermatosurgery without proper training. Like dermatology, dermatosurgery should be formally recognized as a subject. Even a structured three-month training would be far more effective than learning procedures only from conferences.

Q7. What are your hobbies, and how do you manage them alongside a busy practice?

A: Maintaining hobbies becomes very difficult once you are deeply involved in clinical practice. As a child, I collected

stamps. Later, I developed a love for reading, especially works by Rabindranath Tagore, Sarat Chandra Chattopadhyay, Shakti Chattopadhyay, and Sunil Gangopadhyay. Unfortunately, now it is hard to continue reading due to lack of time, concentration, and energy.

Q8. What message would you like to give young dermatologists about finding fulfillment beyond trends and glamour?

A: Do not practice aesthetics only for money. I often recall what my teacher, Dr Ranjit Panja, used to say: you do not have the right to prescribe medications to patients that you would not give to your own family members. He emphasized the word right. Ultimately, you are answerable to yourself. Choose your professional path wisely, so that you have no regrets later in life.

MONTHLY CLINICAL MEETING FOR THE YEAR 2026

Venue	Day	Date	Month
R G KAR Medical College	Friday	27	February
R K M Seva Pratisthan	Monday	30	March
NRS Medical College	Tuesday	28	April
Medical College, Kolkata	Thursday	28	May
College of Medicine & Sagore Dutta Hospital	Wednesday	10	June
IPGMER	Tuesday	28	July
Malda Medical College	Friday	28	August
School of Tropical Medicine	Tuesday	29	September
KPC Medical College and Hospital	Wednesday	28	October
Calcutta National Med. College	Friday	18	December

The meetings will be held at 2.30 p.m. unless specified otherwise. Any change in the above will be notified in our website. You may contact us at (www.iadvlwb.org) or (+91 33 22277553) for any queries. You are requested to attend and participate in the meetings.

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DERMBUZZ :
LASERS IN SKIN OF COLOUR-PRAGMATIC PARAMETERS AND DANGER ZONES

Dr Srutee Barman
Consultant Dermatologist, Kolkata

❖ *Lasers is a revolutionary tool in aesthetic medicine treating various skin concerns worldwide. However they carry pitfalls ,especially in skin of colour. Over time, new innovations have made laser safer for these patients through pragmatic parameters, careful laser selection and clinician expertise.*

❖ ***What is Skin of Color?***

Skin of colour is an umbrella term for skin from diverse racial and ethinic backgrounds, primarily Asia, Middle East and the Mediterranean region, with following key features-

-Increased melanin levels and widely distributed melanosomes in the epidermis.

- Fitzpatrick phototype IV, V & VI .

-contains increased fibroblastic response.

Thus skin of colour goes beyond mere "shade" of skin –its a distinct skin biology.

ADVANTAGES: *Helps in reducing photoageing due epidermal melanin which absobs and scatters UV radiation leading to less epidermal damage, and decreased skin cancer risk. Robust fibroblasts delay ageing with an anti wrinkle effect.*

DRAWBACKS: *In procedural dermatology including lasers, epidermal melanin acts as a competitive chromophore raising risk of epidermal injury leading to post inflammatory hyperpigmentation as well as hypopigmentation. Due to overactive fibroblasts, chances of keloids and hypertrophic scarring after injury is more in our skin type. In this scenario, managing the parameters of laser becomes a challenging task for dermatologists to achieve desired results without complications.*

❖ ***PRAGMATIC PARAMETERS OF LASER:***

In the Indian subcontinent, lasers are indicated for facial hperpigmentation and uneven skin tone ,one of the major aesthetic concern of Indian population . Other indications being hirsutism, acne scars, tattoo removal, various nevi or birthmarks.

The major cornerstone in laser physics are its wavelength, fluence, pulse duration and spot size.

- ***WAVELENGTH****-The longer the wavelength, the safer for melanin rich skin.Nd:YAG laser (1064 nm) is ideal for hair removal and pigment removal changes because of deeper penetration and less epidermal melanin absorption.*
- ***FLUENCE****-Start low;increase.gradually based on patient tolerance and clinical endpoints like "slight erythema".*
- ***PULSE DURATION****-The longer the pulse duration, the better. It should be more than thermal relaxation time(TMT)of the epidermis, i.e. more than 20 ms. Thus the epidermis dissipates the heat, while the target remains hot (as in case of laser hair removal, hair follicles)*
- ***SPOT SIZE****- Larger spot size allows for deeper penetration with less surface scattering sparing epidermis.*

Thus altering these parameters according to the type of laser used in different indications, the desired results can be achieved without complications.

➢ ***LASER FOR HAIR REMOVAL:***

- ***Nd:YAG laser (1064 nm)*** *: ideal due to their longer wavelengths allowing sufficient thermal injury to dark coarse hair, sparing the dermis.* ***Fluence can be initiated from 30 & then titrated till 50 J/cm2 (depends on device, body site & real time end points).***
- ***IPL(Intense Pulsed Light devices)****: produce light with* ***broad range of wavelength*** *which can be adjusted to target particular sites according to requirement minimizing epidermal damage.*
- *A newer technology* ***SHR (Superior hair removal)*** *technique is being used where the dermis is heated to a requisite temperature in rapid, low fluence pulse to destroy the hair follicles, but avoiding epidermal damage due*

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*to simultaneous cooling of the superficial skin by **sapphire dual chill window technology**. These laser contain blends of three lasers (755,810,1064 nm) targeting different depths of hair follicles. Treatment should be done **at interval of 4-8 weeks.***

- ✓ ***END POINT**-mild to moderate erythema, perifollicular oedema. STOP ,if "immediate whitening " occurs(risks of burns).*

➢ ***LASER FOR HYPERPIGMENTATION**:*

- ✓ *The major goal of lasers in hyperpigmentation is to damage excessive melanin in dermis , avoid migration of melanin from dermis to epidermis, while keeping melanocytes intact.*
- ✓ ***Pico/q-switch Nd: YAG laser** : photoacoustic and photomechanical energy is predominantly used instead of thermal injury ,thus reducing chances of PIH.*
- ✓ *"**Laser toning**" i.e. low fluence, large spot size is the ideal method for lasers in melasma. Repeated sessions at **interval of 2 weeks** must be done following a "low & slow" approach. The favourable parameters are **FLUENCE-2.5-3 J/CM2,SPOT SIZE-6-8 mm, Frequency-10Hz with multiple 10-20 passes**. It helps in removing melanosomes without damaging melanocytes.*
- ✓ *For nevi, freckles and lentigenes, **spot size should be 3-5 mm, while fluence should be set at 2.5-5 J/cm2**.*
- ✓ ***END POINT**- slight erythema*

➢ ***LASERS FOR ACNE SCARRING**:*

- ✓ ***Fractional non-ablative lasers**(form microthermal zone [MTZ], target dermis and spares epidermis) are the preferred modality for acne scars.*
- ✓ ***Er:Glass laser (1550 nm)** : recommended and **safe** technology in skin of colour. The technique used here is it creates "microthermal zones"(MTZ) and heat up the dermal collagen while leaving the stratum corneum intact ,thus reducing the risk of PIH. Thus the collagen gets stimulated leading to neocollagenosis, but there is sparing of keratinocyes. The only drawback being requirement of repeated sessions .The preferred parameters are **Energy -15-30 mJ, at LOW DENSITY, 6-8 PASSES & AVOIDANCE OF STAMPING MODES**.*
- ✓ *Fractional CO2 lasers or Er: YAG lasers ,though preferred gold standard due to higher efficacy, but it can be used with highest expertise as being ablative it damages epidermis leading to PIH.*

➢ ***LASERS FOR TATTOO REMOVAL**:*

- ✓ *Removal of tattoo in skin of colour is difficult due to epidermal melanin which acts as competitor of ink particles in dermis.*
- ✓ ***Q switched Nd: YAG (1064/532 nm)** can be used according to ink particle present in tattoo.*
- ✓ ***Low fluence, larger spot size** is the rule. While, for larger tattoo higher frequencies (5-10Hz) and for smaller tattoo lower frequencies (2-3 Hz) must be chosen.*

❖ ***WHAT ARE THE DANGER ZONES IN SKIN OF COLOUR?***

ANATOMICAL BASED	*PROCEDURAL BASED*	*OPERATOR BASED*
▪ **BONY PROMINENCES** mallelous, bridge of nose)-thin skin, absorb more heat causing PIH ▪ **MANDIBULAR LINE & NECK**: Risk of hypertrophic scarring & keloids. ▪ **Upper lip**: PIH due to excessive sensitivity.	▪ ***Tanned skin** –here the entire epidermal skin becomes a target . So, avoid lasers in tanned skin.* ▪ ***Excessive cooling** or cryogen spray may lead to cold burns.*	▪ ***Overlapping of pulses** may lead to cumulative heat causing a blister* ▪ ***High energy** may lead to permanent loss of melanocytes causing confetti like hypopigmentation permanently.* ▪ *Self proclaimed cosmetologist!!*

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❖ ***WHAT ARE THE SAFETY PARAMETERS TO BE CONSIDERED BY PRACTISING DERMATOLOGISTS WHILE DOING LASERS IN SKIN OF COLOUR?***

- ✓ *Prepare a safety checklist of pre-procedure & post procedure protocol.*
- ✓ *Educate the patient about the expected results ,the timeline of the whole procedure, obtain written consent.*
- ✓ *Ask specifically about any H/0 drug intake(Isotretinoin within last 6-12 months),H/o any active infections, H/0 photosensitivity disorders.*
- ✓ ***PATCH TEST**: Perform a test spot (behind the ear),observe for 48-72 hrs for any untoward changes.*
- ✓ ***Pre-procedure protocol**-Proper priming of skin with actives like*

  hydroquinone, retinoids, kojic acid 2-4 weeks before the procedureto downregulate melanocytes. but the actives should be stopped at least 7 days prior to the procedure. Consistent use of broad spectrum, physical sunscreens should be encouraged..
- ✓ *Use **dynamic cooling devices** consistently before and after the procedure.*
- ✓ *In skin of colour,often it becomes difficult to appreciate the clinical end points (eg.redness), in that case must **consider perifollicular oedema, follicular snapping as endpoints.***
- ✓ ***Post procedure protocol** - regular use of physical sunscreens, applying mild topical steroids for 3-5 days post procedure and start actives(tretinoin,glycolic acid, etc.) 7 days after the procedure. Strict sun avoidance, as well as avoidance of strong heat and steam for at least 24-48 hours after the procedure.*
- ✓ *Advise patient to inform if any blister, skin peeling or any undesirable skin changes appear for prompt treatment. **Schedule a follow up of patients 24 hours after the procedure**.*
- ✓ *Always document baseline photographs.*

The doctor patient relationship in aesthetic procedures ,particularly lasers on skin of color, relies on trust, communication , expertise and empathy to address unique skin needs safely. Modern techniques have made these treatments easier, but they demand tailored approaches to minimize risks and get desirable results.

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RESIDENT'S CORNER: PHOTOTHERAPY IN DERMATOLOGY

Dr. Debalina Santra
Senior Resident
ICARE, HALDIA

SUMMARY

Phototherapy, also known as light therapy, is a therapeutic modality that uses specific wavelengths of ultraviolet (UV) radiation to treat various dermatological disorders. It has been an integral part of dermatology for decades and remains one of the safest and most effective non-invasive treatments. The scientific basis of phototherapy lies in the ability of UV light to modulate immune responses, alter cellular proliferation, and induce biochemical changes within the skin.

Phototherapy is an established and effective treatment modality in dermatology that uses ultraviolet (UV) and visible light to manage inflammatory, autoimmune, and proliferative skin disorders. It acts through immunomodulation, anti-inflammatory effects, induction of apoptosis of pathogenic T cells, and regulation of keratinocyte proliferation.

Narrowband UVB (NB-UVB, 311–313 nm) is currently the most widely used form due to its high efficacy and better safety profile compared with broadband UVB. It is first-line therapy for psoriasis, vitiligo, atopic dermatitis, pruritus, and early cutaneous T-cell lymphoma. PUVA therapy (psoralen + UVA) remains useful in recalcitrant psoriasis, thick plaques, and mycosis fungoides, though long-term risks limit its use.

History and Evolution

The therapeutic use of sunlight (heliotherapy) dates back to ancient civilizations. The modern era of phototherapy began with Niels Finsen, who received the Nobel Prize in 1903 for demonstrating the benefits of light in treating lupus vulgaris. Over time, natural sunlight was replaced by controlled artificial UV sources, which led to the development of broadband UVB (BB-UVB), psoralen plus UVA (PUVA), and eventually narrowband UVB (NB-UVB), which is now the most widely used system.

Mechanism of Action

Phototherapy works through multiple mechanisms depending on the wavelength:

1. ***UVB*** *(Broadband and Narrowband)*

Causes DNA photoproduct formation leading to reduced epidermal hyperproliferation.

Induces T-cell apoptosis, thereby decreasing inflammation.

Modulates cytokines and promotes repigmentation in disorders like vitiligo by stimulating melanocyte activity.

2. ***UVA***

Penetrates deeper into the dermis, affecting dermal immune cells.

Requires psoralens (photosensitizers) for PUVA therapy to enhance therapeutic effects through DNA crosslinking.

"While UVB radiation interacts almost exclusively with the epidermis, UVA radiation also reaches the upper dermis. Therefore, UVB radiation is used more for superficial dermatoses affecting the epidermis, while UVA radiation is used for deep dermatoses affecting the dermis"

In phototherapy, ultraviolet radiation is initially absorbed by specific target molecules in the epidermis and dermis. The different depth effects of UV rays and the molecules present in the different layers of the skin determine the clinical applications of phototherapy. UVB radiation is mainly used for superficial dermatoses that manifest mainly in the epidermis. Other dermatoses that also affect the deeper dermis, such as scleroderma, are more likely to require UVA treatment.

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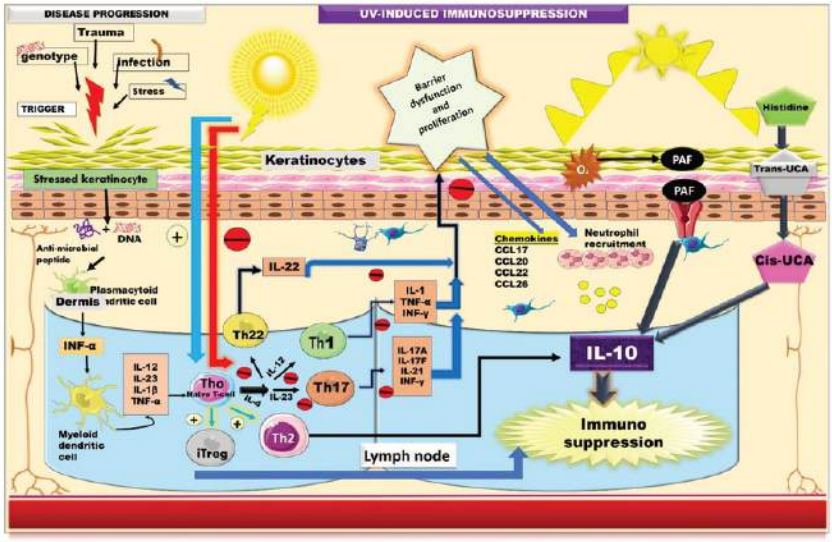
Types of Phototherapy



1. Narrowband UVB (NB-UVB; 311–313 nm)

Currently the gold standard for many dermatoses due to: High efficacy

Having Fewer side effects.

Indicated in psoriasis, vitiligo, atopic dermatitis, pruritus, and many photodermatoses.

2. Broadband UVB

Earlier form of UVB therapy; effective but less commonly used now due to higher erythema risk and lower efficacy compared with NB-UVB.

3. PUVA (Psoralen + UVA)

Psoralens may be taken orally, applied topically, or used in bath water.

Highly effective in psoriasis, vitiligo, mycosis fungoides, lichen planus, and chronic eczema.

4. Targeted Phototherapy

Includes excimer laser (308 nm), excimer lamp, and UVA1 lamps.

Allows focused treatment of localized lesions while sparing normal skin.

'UVA and UVB can generate reactive oxygen species (ROS), which can cause various reactions and damage in cells.'

Direct absorption of UVB energy by DNA components can lead to the formation of covalent bonds between adjacent pyrimidine bases. In particular, exposure to UVB radiation typically leads to the formation of cyclobutane-pyrimidine dimers (CPD), pyrimidine-(6-4-)pyrimidone photoproducts (6-4PP) and Dewar valence isomers. These photochemical reactions contribute significantly to the development of sunburn.11, 33 Furthermore, such a photoproduct can be the starting point for the development of mutations. Of particular importance are the C → T and CC → TT transitions, which are so characteristic of UV damage that they are referred to as signature mutations. It is hypothesized that the chromophore for the sunburn response is DNA, since the spectrum of action of erythema is very similar to the spectrum of action of the formation of direct UV-induced pyrimidine dimer lesions of DNA. This hypothesis is also supported by the observation that xeroderma pigmentosum patients with defects in the repair of these lesions show acute UVB photosensitivity with reduced minimum erythema dose (UVB MED).

'C → T and CC → TT transitions are characteristic of UV damage and are referred to as signature mutations.'

Clinical Indications

Phototherapy is used for a wide range of dermatological diseases:

Psoriasis – one of the most responsive conditions; NB-UVB is first line for widespread disease.

Vitiligo – NB-UVB promotes repigmentation and stabilizes disease.

Atopic dermatitis – reduces inflammation and pruritus.

Cutaneous T-cell lymphoma (CTCL) – PUVA is especially useful.

Lichen planus – responds well to NB-UVB and PUVA.

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Pruritus of various causes – especially in chronic kidney disease and cholestasis.

Photodermatoses such as polymorphic light eruption and chronic actinic dermatitis.

Other conditions: alopecia areata, granuloma annulare, urticaria pigmentosa.

Procedure and Treatment Protocols

Patients undergo 2–3 sessions per week for several weeks to months.

NB-UVB: dosing based on skin phototype or minimal erythema dose.

PUVA: requires psoralen ingestion 1–2 hours before exposure; patients must wear UV-protective eyewear for 24 hours after treatment.

Dose increments are gradual to avoid phototoxicity. Maintenance therapy may be used for chronic diseases.

Dosing -

Usually given 2times per week.

But not on 2 consecutive days.

Start 250 mj/cm2 , increased by 50 mj /cm2 on every 2nd dose.

If patient miss the session then we can go through below.

- *Decreased 50mj/cm2 if miss 2 wks*
- *Decreased by 75 % if missed 3 weeks*
- *Decreased to 250mj /cm2 if missed 4 weeks.*

Skin type	Initial UVB dose	Dose increment after each treatment	Maximum dose
I	130 mJ/cm^2	15 mJ/cm^2	2000 mJ/cm^2
II	220 mJ/cm^2	25 mJ/cm^2	2000 mJ/cm^2
III	260 mJ/cm^2	40 mJ/cm^2	3000 mJ/cm^2
IV	330 mJ/cm^2	45 mJ/cm^2	3000 mJ/cm^2
V	350 mJ/cm^2	60 mJ/cm^2	5000 mJ/cm^2
VI	400 mJ/cm^2	65 mJ/cm^2	5000 mJ/cm^2

UV: Ultraviolet

FLOW CHART

Patient for NB-UVB phototherapy

⬇

Assess Fitzpatrick Skin Type (I–VI)

⬇

Decide Starting Dose (mJ/cm^2)

⬇

Monitor erythema after 24 hours

⬇

No erythema → Increase dose by 10–20% next session

Mild erythema (asymptomatic) → Repeat same dose

Painful erythema / blistering → Withhold treatment until recovery, then restart at 50% of last dose

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STARTING NB-UVB DOSE BY SKIN TYPE

Fitzpatrick Skin Type	*Skin Characteristics*	*Starting Dose (mJ/cm²)*
Type I	*-Always burns, never tans*	*200 mJ/cm²*
Type II	*-Usually burns, tans minimally*	*250 mJ/cm²*
Type III	*-Sometimes mild burn, tans uniformly*	*300 mJ/cm²*
Type IV	*-Rarely burns, tans well*	*350 mJ/cm²*
Type V	*-Very rarely burns, deeply pigmented*	*400 mJ/cm²*
Type VI	*-Never burns, deeply pigmented*	*450 mJ/cm²*

DOSE INCREMENT (COMMON PRACTICE)

Increase by 10–20% per session

Frequency: 2–3 sessions/week

Maximum dose varies by disease and patient tolerance.

IMPORTANT CLINICAL NOTES

Reduce starting dose in children, elderly, facial involvement, genital exposure

Avoid treatment on photosensitizing drugs

Eye protection and genital shielding mandatory

Advantages of Phototherapy

It is a Non-invasive and generally safe & Suitable for children, pregnant women (except PUVA).It is more Effective for widespread lesions.It has Minimal systemic side effects compared with oral immunosuppressants

Can be combined with topical agents for enhanced results.

Limitations and Side Effects

Though generally safe, phototherapy has certain drawbacks:

Short-term side effects

Erythema (sunburn-like reaction)

Pruritus

Dryness

Tanning

Phototoxicity (especially with PUVA)

Long-term risks

Photoaging

PUVA increases risk of squamous cell carcinoma and, to a lesser extent, melanoma

Cataracts (if eye protection is not used)

NB-UVB has a lower carcinogenic risk compared to PUVA, making it safer for long-term use.

Recent Advances in phototherapy

Excimer devices allow targeted high-dose therapy with fewer sessions.

UVA1 therapy (340–400 nm) shows promise for sclerosing and inflammatory dermatoses.

Conclusion

Phototherapy remains a cornerstone of dermatological treatment due to its efficacy, safety, and versatility. From psoriasis to vitiligo and various photodermatoses, it offers significant clinical benefits with minimal systemic toxicity. Advances in technology continue to refine and expand the role of phototherapy, making it an indispensable tool in modern dermatologic practice.

LIST OF HOLIDAYS FOR THE YEAR 2026

The following days will be observed as holidays in the IADVL,WB office during the year 2026

Holiday Name	Day	Date	Month
Swami Vivekananda Jayanti	Monday	12	January
Netaji Jayanti	Friday	23	January
Saraswati Puja	Friday	23	January
Republic Day	Monday	26	January
Dol Purnima	Tuesday	03	March
Eid al-Fitr	Saturday	21	March
Good Friday	Friday	03	April
Dr. B R Ambedkar Jayanti	Tuesday	14	April
Bengali New Year	Wednesday	15	April
Labour Day	Friday	01	May
Rabindranath Tagore Jayanti	Saturday	09	May
Eid ud zuha	Wednesday	27	May
Muharram	Friday	26	June
Independence Day	Saturday	15	August
Janmashtami	Friday	04	September
Gandhi Jayanti	Friday	02	October
Mahalaya	Saturday	10	October
Maha Saptami	Sunday	18	October
Maha Ashtami	Monday	19	October
Maha Navami	Tuesday	20	October
Dussehra	Wednesday	21	October
Laxmi Pooja	Sunday	25	October
Deepavali	Sunday	08	November
Guru Nanak Jayanti	Tuesday	24	November
Christmas Day	Friday	25	December

** The Holidays declared by West Bengal Government under N I Act to be considered.*

The office hours: Weekdays: 11.00 am to 05.00 pm | Saturdays: 11.00 am to 03.00 pm

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DERMAGINATIONS:
PAGING PASSION BEYOND PRACTICE

কষ্ট যেথা মনের মাঝে
বিলীন হয়ে যায়।
ইচ্ছা যেথা নতুন বাঁকে
চেনা সে পথ পাই।
লক্ষ্য যেথা সীমাহীন,
সিংহ বল বুকে।
মাথা যেথা উচ্চ সদা,
অন্যায়ে না ঝুঁকে ।
বাঁচার ইচ্ছা প্রবল,
আর মরার নেইকো ভয়।
বাঁচা যেথা সূর্যের দিকে ,
নিজ দূর্বলতাকে জয়।

পথ চলা অস্তিত্বের মধ্যে
নিয়ে অনস্তিত্বের ভাবনা।
পৃথিবী যেথা সুন্দর,
কষ্ট যেথা কম না।
অসন্তোষ যেথা নিজের উপর,
ভালো চাওয়া অন্যের।
আত্ম-পর ভেদ যেথা লুপ্ত,
আর প্রকাশ কৃষ্ণের।
সেথা সেই অনভুতি,
যোগীদের আশা।
মীরার শ্রীকৃষ্ণের তরে
সেই ভালবাসা।

Dr. Malay Sankar Mondal

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HIV-AIDS & ITS DERMATOLOGICAL IMPORTANCE

Dr Shatanik Bhattacharya
Senior Resident
P C Sen Govt. MCH, Arambag

***World AIDS Day**, observed annually on December 1st, aims to raise awareness, fight stigma, and honor those affected by HIV/AIDS.*

The 2025 theme is "Overcoming Disruption, Transforming the AIDS Response," that focuses on rebuilding stronger HIV services disrupted by global crises, ensuring equitable access, and renewing commitment to ending AIDS by 2030 through resilient systems and human rights.

Goals:

- *Rebuild & Strengthen: Renewing HIV care, prevention, and testing services.*
- *Equity: Ensuring inclusive care and removing barriers like stigma.*
- *Resilience: Creating systems that can withstand future challenges.*
- *Innovation: Embracing new approaches, like long-acting treatments.*
- *End AIDS: Moving closer to the 2030 global target.*

***Dermatologists** are crucial in HIV awareness because skin and mucous membrane issues (like unusual rashes, sores, or infections) are often the first visible signs of HIV, acting as sentinel markers for early diagnosis, especially for those unaware of their status. They help diagnose HIV through these signs, manage treatment side effects, monitor opportunistic infections, and educate patients on skin health, playing a vital role in both early detection and ongoing care, particularly in resource-limited settings.*

Key Points for Dermatologists on the Burden of HIV

- *High Prevalence: Over 90% of people living with HIV (PLWH) develop at least one skin symptom during their infection.*
- *Sentinel Signs for Early Diagnosis: Unusual or severe skin conditions (e.g., severe seborrheic dermatitis, shingles in young adults) should prompt immediate HIV testing.*
- *Shifting Spectrum (ART Era):*

Pre-ART: Dominated by Kaposi sarcoma, extensive molluscum, and opportunistic infections.

Post-ART: Increased prevalence of chronic, severe inflammatory skin diseases (psoriasis, atopic dermatitis, acne) and malignancies as patients live longer.

- *Prevalent Cutaneous Conditions:*

Infections: Oral candidiasis, dermatophytosis (tinea), seborrheic dermatitis, and herpes zoster.

Inflammatory: Xerosis (dry skin), pruritic papular eruptions (PPE), and psoriasis.

Neoplastic: Kaposi sarcoma (800-fold increased risk) and non-melanoma skin cancers (SCC and BCC).

Immune Reconstitution Inflammatory Syndrome (IRIS): Paradoxical worsening of skin conditions (e.g., acne, folliculitis) can occur shortly after initiating ART due to an exaggerated immune response.

High Risk for Severe Drug Reactions: PLWH have a 1000-fold higher risk of severe cutaneous adverse drug reactions (e.g., SJS/TEN) compared to the general population, frequently linked to sulfonamides and antiretrovirals.

Association with CD4 Count: The severity and type of skin disease often correlate with immunosuppression; for example, eosinophilic folliculitis typically appears when CD4 counts are <300 cells/mm^3.

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Treatment Challenges: HIV-related skin diseases are often more resistant to standard therapies, recur frequently, and may require systemic treatments.

Key Roles in HIV Awareness & Care:

Early Detection & Diagnosis:

- *Identifying Sentinel Signs: Recognizing conditions like oral thrush, shingles, Kaposi's sarcoma, or unexplained rashes that signal immune compromise.*
- *Screening: Testing patients with suspicious skin/STI symptoms (like genital warts or syphilis) for HIV, as STIs are often co-diagnosed.*

Patient Education & Management:

- *Explaining Skin Manifestations: Educating patients on how HIV affects skin and how to manage conditions like dry skin, fungal infections, or drug-induced rashes.*
- *Managing Co-infections: Treating skin-related STIs (like HPV/warts) that increase HIV risk or severity, and managing opportunistic infections.*

Research & Treatment:

- *Defining HIV-Related Conditions: Describing new skin diseases linked to HIV and understanding drug side effects.*
- *Advocacy: Pushing for essential dermatological care in global health initiatives, especially in regions with high HIV burden like Africa.*

Monitoring Disease Progression:

- *Linking Skin to Immunity: Using skin issues to gauge immune status (CD4 counts), guiding treatment decisions and understanding disease severity.*

In essence, dermatologists bridge the gap between a visible skin problem and a systemic HIV diagnosis, making them frontline contributors to HIV awareness, diagnosis, and holistic patient management. While highly active antiretroviral therapy (HAART/ART) has shifted the spectrum from acute infections to chronic, often more severe, inflammatory conditions, the dermatologist remains critical for early diagnosis, managing complex opportunistic infections, and addressing drug-related skin toxicities.

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Derma–Rheumat Interface: An Insightful Academic Confluence on 5/12/2025 at The Park Hotel, Kolkata

The IADVL West Bengal State Branch successfully hosted the academic meet "Derma–Rheumat Interface" on 5th December 2025 at The Park Hotel, Kolkata, bringing together eminent dermatologists and rheumatologists on a common scientific platform. The program aimed to highlight the growing clinical overlap between the two specialties and the importance of a multidisciplinary approach in patient care.

The session was chaired by Dr. Dinesh Kumar Hawelia, President, IADVL WB, and Prof. (Dr.) Gautam Banerjee, Ex-HOD, School of Tropical Medicine, Kolkata. Esteemed faculty members including Dr. Aditi Chakrabarti, Dr. Somenath Sarkar, Dr. Pradyot Sinhamahapatra, Dr. Kaushik Basu, Dr. Abhijit Saha, and several other distinguished speakers delivered insightful, case-based, and evidence-driven presentations.

Key discussions revolved around autoimmune and inflammatory disorders, shared pathogenetic pathways, pediatric dermato-rheumatologic conditions, and the evolving role of biologics in treatment. The sessions encouraged active interaction, practical learning, and cross-specialty understanding.

Under the able guidance of Dr. Suchibrata Das, Honorary Secretary, IADVL WB, and Dr. Sudip Kumar Ghosh, Convenor, IADVL WB Academy, the program was executed seamlessly. The event witnessed enthusiastic participation from postgraduate students, residents, and practicing clinicians, making it an academically enriching and collaborative experience.

The conclave successfully strengthened the bridge between dermatology and rheumatology, reinforcing the need for integrated care in complex systemic diseases.

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Monthly Clinical Meeting of IADVL WB on 22/12/2025 at Calcutta National Medical College & Hospital, Kolkata

The monthly Clinical Meet was held on 22 December 2025 at the Department of Dermatology, Calcutta National Medical College, Kolkata. The meeting was graced by the presence of eminent faculty members Dr. Kishalay Ghosh, Dr. Sudip Das, and Dr. Saswati Halder, along with active participation from postgraduate residents representing various medical colleges.

The scientific discussion featured several interesting and rare dermatological cases. Superficial Acral Onychofibromyxoma was presented by Dr. Mukti Halder, followed by Diffuse Cutaneous Mastocytosis presented by Dr. Akash Dasadhikary, and Hereditary Carotenoderma by Dr. Amrita Datta, highlighting metabolic causes of skin discoloration.

This was followed by a discussion on an uncommon pediatric genodermatosis, Marshall Syndrome, presented by Dr. Sony Sah. Dr. Anirban Samanta presented a challenging case of Lichen Planus Hypertrophicus with reactive hyperkeratosis/cutaneous horn formation secondary to chronic dermatitis due to Fevikwik exposure, which closely mimicked malignancy and emphasized the significance of occupational and contact exposures in dermatological diagnosis.

The session concluded with a thought-provoking case presented by Dr. Subhartha Mukherjee, most suggestive of Lichen Scrofulosorum, which remained open for further discussion.

The meet concluded with faculty-led discussions underscoring the importance of meticulous clinical evaluation and appropriate diagnostic work-up in arriving at accurate diagnoses of uncommon dermatological conditions.

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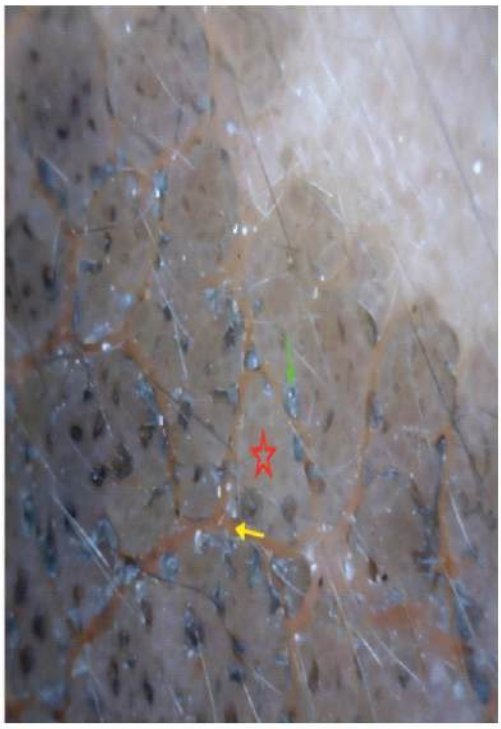
Quiz Zone

1. *What is this dermoscopic sign? Where is it found? (PIC 1)*
2. *Dermoscopic picture of nail plate. What is the diagnosis? (PIC 2)*
3. *What is this sign? (PIC 3)*
4. *What is this sign? In which condition is it seen ? (PIC 4)*
5. *What is the recent fda approved drug for chronic spontaneous urticaria?*



PIC 1

PIC 2

PIC 3

PIC 4

Quiz Answer Volume-3, Issue-8

1. *Androgenic alopecia. Hair shaft diameter variations more than 20%.*
2. *Bullous striae distensae*
3. *Allgower- Donati suture. Used in lower limb to reduce the tension closure.*
4. *Mastocytosis.*
5. *Oral verruciformis xanthoma*

The correct response given: Dr. Shatanik Bhattacharya for Quiz

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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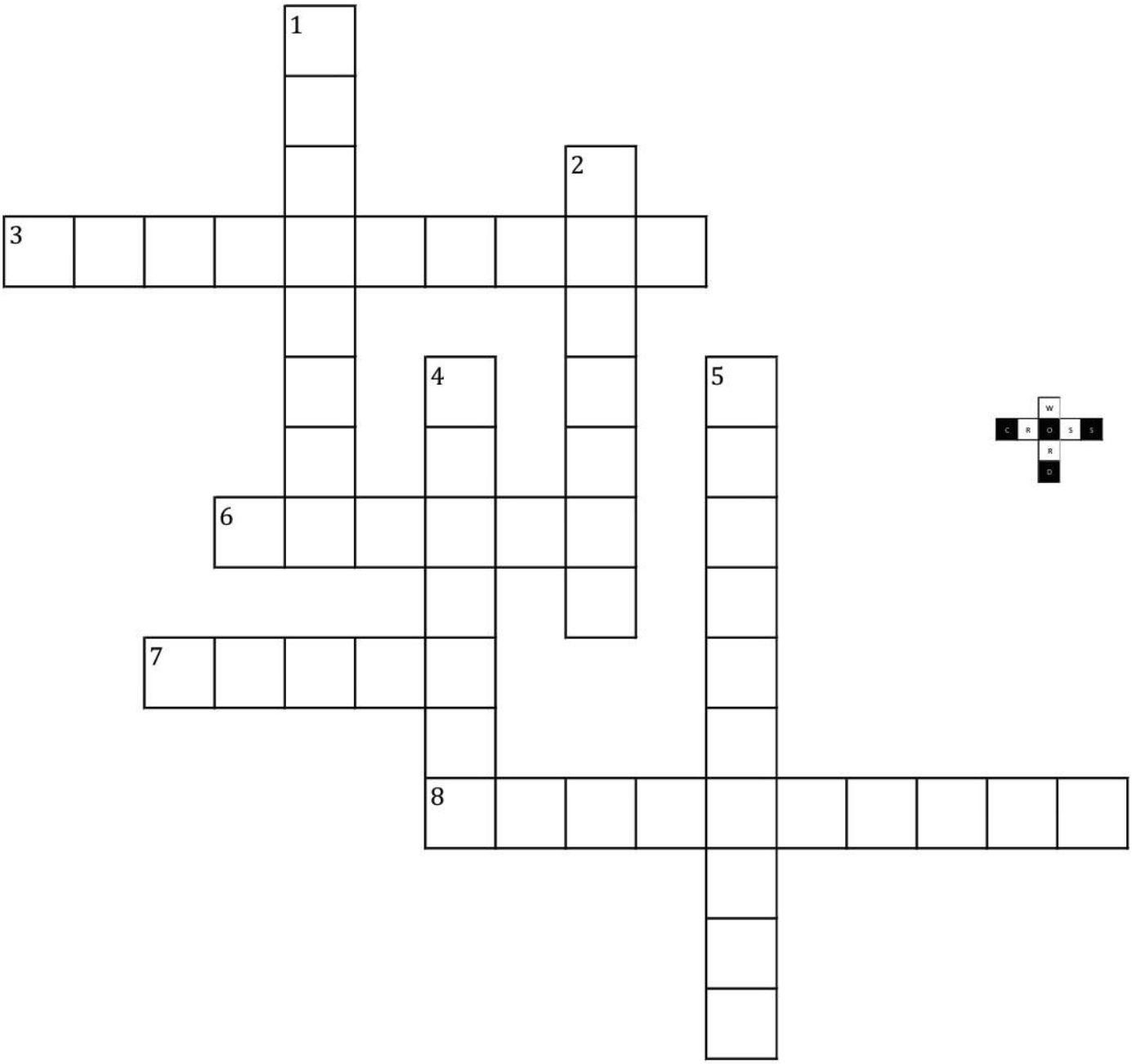
Brainstorm

Across

3. A nitric oxide-releasing agent utilized for the topical treatment of molluscum contagiosum in patients 1 year of age and older
6. Donovanosis was first recognized by Kenneth McLeod in this city
7. A triad of arthropathy. urticaria, and CNS involvement is the hallmark of this syndrome
8. "_____flap": nail surgery typically performed in the setting of longitudinal melanonychia or erythronychia

Down

1. Beauty and the beast sign on dermoscopy is seen in
2. Upconverting Reporter Particle-Lateral Flow Assay (UCP-LFA) is used in diagnosis of
4. Minimally invasive method works by creating a supportive mesh, activating growth factors and stimulating hair growth in AGA
5. Jigsaw Puzzle appearance seen in



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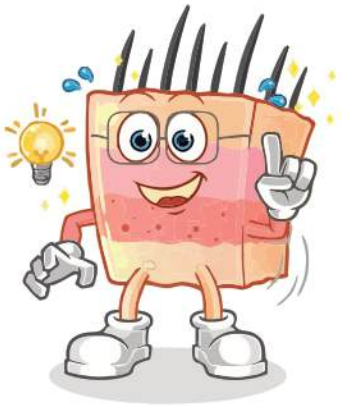
Dermwiz

I
travel by
contact, leave silent
domes,
Carry old genes in
cytoplasmic homes.
Neither rash nor pain
betrays my stay—
What quiet visitor
marks the



Dermwiz Answer
Volume-3, Issue-8

Chancroid

Answer
Volume-3, Issue-8

					[1] H						
					A		[2] B				
[3] L	E	B	R	I	K	I	Z	U	M	A	B
					R		C				
[4] K	O	L	K	A	T	A					
					N		L				
							U				
		[5] F				[6] P					
		I		[7] F	L	A	M	B	E	A	U
		L				G				M	
[8] Z	O	L	I	F	L	O	D	A	C	I	N
		E				D				D	
		T				A				E	