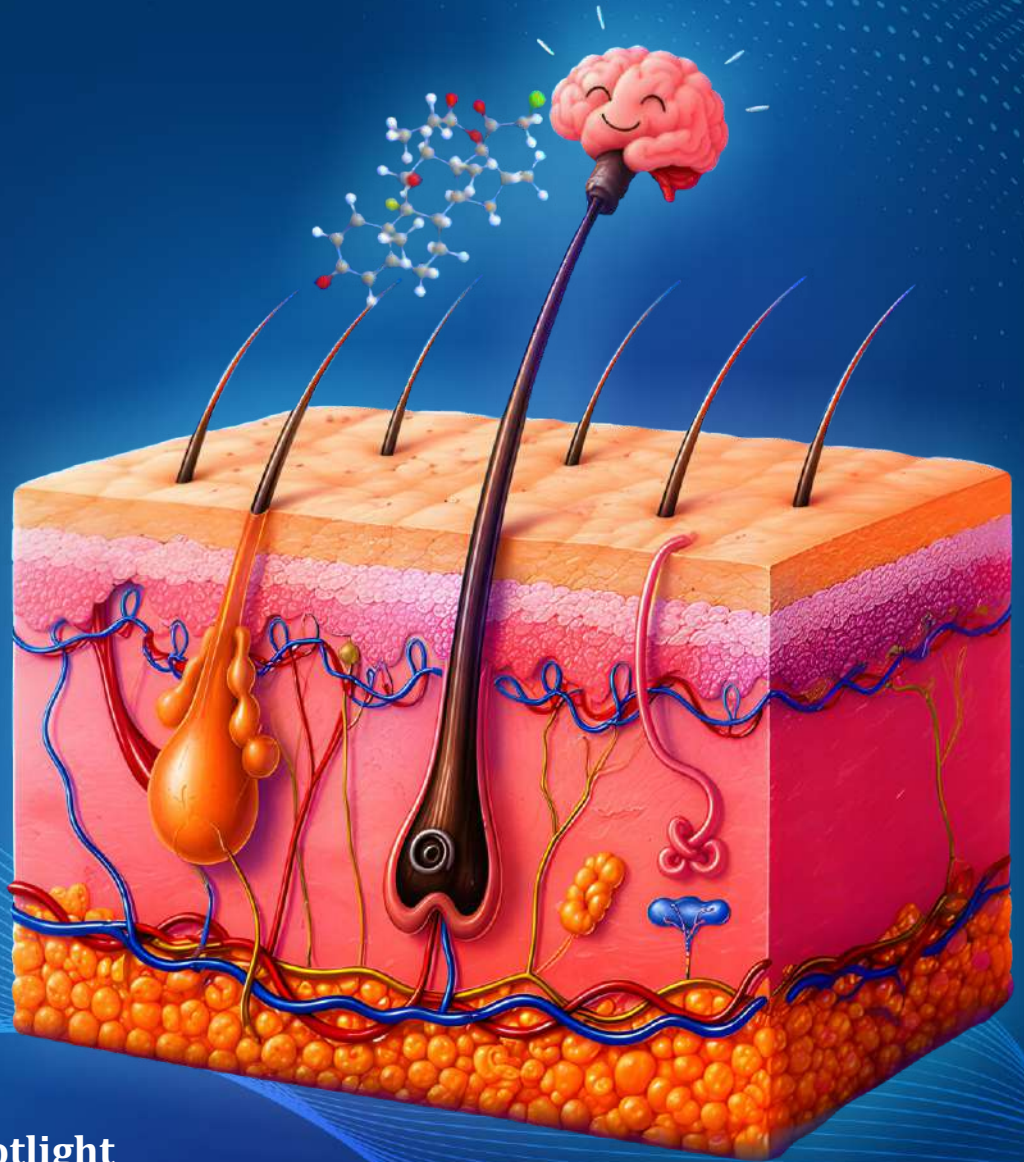




SKINTELLECT

The Official Newsletter of the IADVL West Bengal State Branch



Issue Spotlight

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- 🔪 DermBuzz: Aesthetics Meets Precision
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"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.



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Volume 4 Number 02
June 2026

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Note from the President

Dear Esteemed Colleagues,

Warm greetings from IADVL WB.

As we progress through this year's organisational and academic calendar, I am heartened to see the enthusiasm and dedication of our members. The enthusiasm with which both our senior and junior colleagues contribute their valuable time continues to ensure the success of our initiatives.

Our newsletter Skintellect is now reaching readers across India, a testament to the commitment of our Editorial team. I extend my heartfelt congratulations and best wishes to our Editor and her team for the wonderful work they are doing, and look forward to many more enriching issues ahead.

Let us carry this momentum forward, working together with renewed purpose to strengthen and grow our association.

Long live IADVL.

Warm regards



*Dr. Arghyaprasun Ghosh
President
IADVL WB*



Secretary's Scribes

Dear Esteemed Members and Readers,

It gives me immense pleasure to present the second issue (of my tenure) of Skintellect, the official academic and literary voice of our vibrant state branch. The enthusiastic response to the inaugural issue was truly encouraging, and it reaffirmed our collective commitment to academic growth, knowledge sharing, and creative expression within our dermatology community.

This issue continues our vision of creating a platform that reflects the intellectual depth, clinical expertise, and innovative spirit of our members. Skintellect is not only a repository of scientific updates and clinical insights, but also a space that celebrates experiences, perspectives, and the human side of dermatology. Through case discussions, reviews, opinion pieces, and creative contributions, we aim to foster learning, collaboration, and inspiration.

I sincerely thank the editorial team for their dedication and tireless efforts in bringing out this issue with such quality and finesse. My gratitude also goes to all contributors whose valuable submissions make this publication meaningful and enriching.

I encourage every member to actively participate in future issues—by sharing your work, experiences, and ideas—so that Skintellect continues to grow as a reflection of the strength and unity of our association.

Wishing you all happy reading and continued academic excellence.

With Warm regards,



*Dr. Somenath Sarkar
Honorary Secretary
IADVL WB*



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Volume 4 Number 02
June 2026

Editors Desk

Dear Readers,

Greetings!

The editorial team is delighted to bring you the second issue of Skintellect.

This edition highlights one of the most significant academic events of the month—Gurubani held at school of tropical medicine . Designed as a real-world simulation of the MD final examination, the event brought together postgraduate trainees from various medical colleges for an enriching and intellectually stimulating learning experience.



This month there were two insightful clinical meets one at NRS medical college and another at Medical college Kolkata. We also had an interesting cme on haircare management at JW Marriot.

Our spotlight feature this month shines on the highly respected Dr. Nilay Kanti Das ,who has graciously shared his invaluable experiences, insights, and reflections with our readers. His journey and wisdom are certain to inspire both budding and seasoned dermatologists alike.

In the Dermbuzz section, Dr. Somnath Das has explained us about the body contouring procedures.

Dr Arunima Laha , has given us insights about dermatological misnomers. We also have an interesting case in our case podium contributed by Dr Saswati Halder and her team from school of tropical medicine.

Our popular Brainstorm section returns with an exciting blend of crossword puzzles, quiz challenges, and DermWiz, designed to test your knowledge and make learning dermatology enjoyable.

This issue of Dermaginations features Dr Sabarna Samanta , who presented her amazing drawing skills.

Last but certainly not least, Dermatimes brings to an update on zasocitinib .

We hope this issue informs, inspires, and entertains you in equal measure.

Happy Reading!

Warm regards,

Dr. Ameli Sarkar

Editor, Skintellect,

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CONDOLENCE MESSAGE



Dr. Ashim Kumar Maitra

13th May 2026

With a heavy heart, we, on behalf of the IADVL West Bengal State Branch, express our profound grief and sorrow at the untimely demise of our esteemed senior life member [LM/WB/2476], Dr. Ashim Kumar Maitra, who passed away on 13th May 2026.

He was a tremendously dynamic, ever-smiling person whose contributions to the field of Indian dermatology were immense. His leadership and warmth have left an indelible mark, marking the end of an era. His passing is a great loss to our community.

On this sorrowful occasion, we convey our deepest and heartfelt condolences to his bereaved family and pray to the Almighty that his departed soul may rest in eternal peace.

With deepest sympathy,



DERMATOLOGIST SPOTLIGHT: DR. NILAY KANTI DAS

1. *Sir, it is a privilege and honour to have you with us in this edition. Could you share what inspired you to choose dermatology as your career?*

A. *Let me be very truthful, choosing was by choice since my favorite MBBS teacher once told me that "its better to be a big fish in a small pond rather than a small fish in a big pond". Then with serendipity the decision of choosing dermatology came as a blessing once I realised that no one was going to advise me to complete a DM or MCH once I completed my MD.*

2. *Over the years, you have made remarkable contributions in the field of leprosy. What sparked your special interest in this disease?*

A. *Its not only about leprosy but all neglected tropical diseases . In 2003, I remember my meeting with Late Dr AK Bajaj in CUTICON WB dinner, who suggested the idea of doing research on something very indigeneous to our population where there is huge scope as you have more access to that population than the Western world . Thats the way we can serve the people we are surrounded with and make the world understand the health condition of India. I am indebted to Bajaj sir for implanting that idea in my heart so that my brain could focus on Neglected Tropical Diseases.*

3. *Despite advances in healthcare, missed and delayed diagnosis of leprosy still occur. In your opinion, what are the most common reasons behind this ?*

A. *The reason is multifactorial and I perceive three main aspects to it. From the patients perspective, patients don't seek treatment due to stigma attached with leprosy. Another reason is governmental attitude . At some point of time , there were government officials who were eager to show that the prevalence in their region was under 1 per 10,000 by under reporting. The last but not the least is that we have to acknowledge the fact that there are not many doctors in our discipline who are really interested in leprosy. It has unfortunately rendered some rust on the clinical acumen in its diagnosis as well as treatment.*

4. *During your residency years, was there any teacher or mentor who left a profound influence on your academic and professional journey?*

A. *I have been blessed with some of the most illustrious teachers. I started my journey with Professor SR Sengupta and Prof RN Datta . What I am today in dermatology is because of Prof SR Sengupta. He used to rebuke us, the PGs, as a routine after every morning round that we are not studying well. Late Dr. RN Datta trained me on soft skills which is often missed in our curriculum. During PG days itself I was lucky to work with Professor Mitali Chatterjee who had a lot of influence on me when it came to research. After that I got the opportunity to work with Dr PK Dutta and thereafter Dr Debabrata Bandhopadhyay, the two stallwarts of Dermatology.*

5. *In such an illustrious career, you must have encountered many challenging cases. Would you like to share one particularly difficult or memorable case that had a lasting impact on you as a clinician ?*

A. *There are many such cases. I remember one case of SJS TEN with 98% skin involvement . At that time we were not using Cyclosporine . The patient party were nursing staff. Barrier nursing is what is needed to support for the skin failure. I was amazed how a person can be recovered by proper barrier nursing . From there onwards I always focus on the importance of barrier nursing in SJS TEN cases apart from the pharmacological aspect.*

6. *Having mentored generations of postgraduate trainees, what are some of your most cherished memories as a teacher?*

A. *All my students are my teachers and I have learned so much from them , more than any books or teacher. However if I have to mention one moment, it was in DERMACON 2020 Pune when two of my students Dr Adrija Dutta and Dr Somodyuti Chandra both bagged prizes, one for best thesis award and another for best article (our IJDVL article) . Usually , most of these prizes are captured by people from central institutes like PGI, AIIMS or JIPMER; but this was a moment I could get up on the stage twice during the valedictory because of my students.*





7. *Clinical research and trials are becoming increasingly important in modern dermatology. What advice would you give to young dermatologists aspiring to pursue this field?*
 - A. *Being a clinician we should find new methods of treatment and that is what clinical trial aims at. The advantage of clinical trials lies in the fact that it can be conducted even in resource poor setting because you don't need laboratories with high end equipments. I always insist that research is something which should be done ethically with no injustice to patients and no fabrication of data or plagiarism. We should focus on 5 parameters while choosing the topics of research, namely, feasibility, interest, novelty, ethics and relevance. Another important thing is that clinical trials must be registered under CTRI before starting it.*
8. *Research publication is often a daunting task for postgraduate trainees. What guidance would you offer young researchers regarding academic writing and publishing?*
 - A. *If you have to publish, then think about why an editor should want to publish it. So novelty is very important. Think of something new. Me and Dr Dipankar De have published an article on how to publish your thesis in Indian Journal of Post Graduate Dermatology, which can give the guidance to any postgraduate in this regard. In a nutshell, Focus on publication just after you submit your thesis, since that's the time it's very fresh in your mind. After your thesis is submitted you should narrow down the 100 page work into a 3000 word article. You should try to publish your work in indexed journals.*
9. *Sir, you have been honoured with numerous awards and recognitions throughout your distinguished career. Among them, is there one that holds a particularly special place in your heart, and why?*

Each and every award is special to me. My post graduates have helped a lot in my achievements.
10. *Beyond the realm of dermatology, what hobbies or personal interests do you enjoy, and how do you manage to balance them with your professional commitments?*

I am an avid bird watcher. Even during conferences, one morning I find time to photograph birds.
11. *Any memorable PKDL case you have come across in your career?*

I remember one 14 year old child treated for leprosy. The child was an orphan and stayed in a leprosy home. He was not cured and was brought to school of tropical medicine. We figured that he was suffering from PKDL and not leprosy. The next time he came, an attendant of the leprosy home said he was being ousted from the home as he was not suffering from leprosy. It hit me hard that the person was losing his home so I had to write that he was suffering from leprosy and later developed PKDL



DERMBUZZ :

“THE SCIENCE OF SLIM: WHERE AESTHETICS MEETS PRECISION”

Introduction: An aesthetic surgeon is an artist at core that sculpts human body to desired curves and angles using the power of science and advanced technology.

Body sculpting is the new buzz-word in town but it dates back century ago in 1924 when Thorek performed umbilicus preserving abdominoplasty.

Definition: Body contouring (Body Sculpting) constitutes invasive and non-invasive procedures that remove excess fat, tighten sagging skin and toned muscles, aimed at reshaping specific body areas.

Types: It can be broadly classified into surgical/invasive procedures and non-surgical/non-invasive procedures. Dermatologists and aestheticians are more concerned with non-invasive techniques while surgical techniques are the forte of plastic surgeons.

Surgical techniques involve incisions, general anaesthesia & recovery period and provides dramatic, long-lasting results. Candidates for surgical technique are those who usually undergo major weight loss and have excessive sagging skin. Risks of scarring and infection are more in this technique.

Non-invasive techniques target small areas of stubborn fat and mild skin laxity. It is not suitable for weight loss or treating obesity. It is mainly used for fine-tuning of body sculpture. There is no incision and patients return rapidly to their daily routine. It uses advanced technologies to induce fat necrosis which is cleared by immune cells over several weeks or to stimulate collagen production. Multiple sessions are needed and each session lasts approximately 30 minutes. Results are subtle and gradual.

Surgical techniques include:

- 1) Liposuction
- 2) Tummy tuck (Abdominoplasty)
- 3) Breast Lift/Breast Reduction
- 4) Thigh Lift
- 5) Arm Lift (Brachioplasty)

Non-surgical techniques include:

- 1) Cryolipolysis – uses controlled fat freezing to target stubborn fat pockets like lower abdomen, love handle, thigh and under-chin. There is 20 to 25% reduction in fat layer thickness per session. CryoSculpt uses a wand like massager that induces alternate hot-cold cycles while CoolSculpt employs use of vacuum applicator. Side effects include redness, bruising, pain and temporary numbness.
- 2) Radiofrequency (RF): uses RF waves to vibrate water molecules within fat cells causing shrinkage of fat cells and to stimulate collagen production causing improvement in skin laxity. It penetrates 20 mm deep and raises temperature to 40-42°C. It is best suited for cellulite reduction.
- 3) Electromagnetic Stimulation- Devices like EMSCULPT uses HIFEM (High Intensity Focused Electromagnetic) to induce supramaximal contractions in muscles resulting in muscle hypertrophy and hyperplasia. It targets abdomen, buttock, thighs, calves. It is suitable for post pregnancy abdominal muscles strengthening. Side effects include temporary muscle weakness and tenderness.
- 4) Laser Lipolysis- devices like SculpSure uses laser energy to stimulate collagen production and induce lipolysis. Around 24% fat cells reduction at target area, is achieved per session. Body area targeted includes abdomen, flanks and thigh.

Dr. Somnath Das
Assistant Professor,
Sarat Chandra Chattopadhyay
Govt. Medical College, Uluberia





5) *Ultrasound- Low frequency High Intensity Focussed Ultrasound (HIFU) generates micro bubbles within fat cells and destroys fat cells which are cleared by lymphatic system. It generates heat which stimulates collagen and elastin production.*

Pros and cons of Body Sculpting:

Cons:

1. *Body sculpting cannot be used for treating obesity and weight reduction. Patients with near ideal body weight are candidates for body sculpting*
2. *Expensive*
3. *Needs 3-6 months for results to be visible*
4. *Rare side effect of paradoxical adipose hyperplasia which needs additional fat corrective surgery*
5. *Healthy diet and exercise needs to be combined with body sculpting to maintain long-term results*

Pros:

1. *Versatile procedure which can target any area with stubborn fat*
2. *Long lasting results*
3. *Natural looking results*
4. *No downtime with immediate return to daily life*

Conclusion: It needs more effort to maintain a picture perfect body than creating it. The importance of regular exercise and healthy diet should be emphasized to every candidate of body sculpting. Body sculpting is not the core to achieve a perfect and slim body but only an accessory tool to fine tune the end results.



RESIDENT'S CORNER: DERMATOLOGY MISNOMERS: BRIDGING THE GAP BETWEEN TERMINOLOGY AND TRUTH

"If there ever was a misnomer, it is 'exact science.' Science has always been full of mistakes," as Edward Teller famously observed. Historically, medicine has struggled with precise nomenclature. Ancient Greek, Roman, and Arab physicians often named conditions based solely on their morphological appearance rather than their true nature, leading to an inevitable accumulation of errors. As a distinctly "perceptual specialty," dermatology harbors some of the most persistent and instructive naming errors.

Dr. Arunima Laha
1st Year, PGT,
IPGMER and SSKM Hospital



By definition, a misnomer inaccurately describes a disease's etiology, pathology, morphology, or clinical behavior. While some of the misnomers encountered in dermatology originated from a lack of pathophysiological understanding at the time of their coinage, others stem from imprecise linguistic translations.

Today, despite significant leaps in dermatopathology and molecular medicine, many misleading terms remain in routine clinical practice due to widespread familiarity—a linguistic inertia that stubbornly resists correction. Awareness of these discrepancies is not merely an academic exercise for the clinicians, it is essential for accurate diagnosis and effective communication with patients.

A Compendium of Dermatological Misnomers

- *Tinea Versicolor: The term "tinea" is derived from Latin word for "worm" and traditionally denotes a dermatophyte infection. However, the preferred and accurate term is Pityriasis versicolor, as it is caused by the lipophilic yeast Malassezia furfur (and related species). The condition is a saprophytic overgrowth, not a dermatophyte infection.*
- *Pyogenic Granuloma: This lesion neither produces pus ("pyogenic") nor is it a true histological granuloma. It is actually a benign vascular proliferation featuring lobular aggregates of capillaries set within an edematous stroma. Thus, "lobular capillary hemangioma" is the more accurate histopathological term.*
- *Hidradenitis Suppurativa: The name falsely implies an initial inflammation of the sweat glands ("hidradenitis") alongside suppuration. Current evidence points to follicular hyperkeratosis occlusion as the primary pathogenic event. Terms like "acne inversa" more accurately capture the follicular origin of this debilitating condition.*
- *Mycosis Fungoides: Coined by Jean-Louis-Marc Alibert in 1806, the nomenclature incorrectly implies a fungal disease because the advanced tumorous lesions resembled mushroom-like growths. In reality, it is a form of cutaneous T-cell lymphoma with no fungal etiology, reflecting morphology rather than true pathogenesis.*
- *Adenoma Sebaceum: Historically, the classic facial papules of Tuberous Sclerosis were thought to represent adenomas of the sebaceous glands. Histologically, they are actually angiofibromas—benign hamartomatous proliferations composed of fibrovascular tissue. This persistent historical inaccuracy ignores modern dermatopathologic advances.*
- *Lupus Vulgaris: Derived from the Latin word for "wolf," this term historically described destructive facial lesions that looked as though the skin had been devoured by a wolf. It refers to cutaneous tuberculosis—a granulomatous infection caused by Mycobacterium tuberculosis—and bears no association to Systemic Lupus Erythematosus.*
- *Chicken Pox: This widely popular term describes the viral exanthem caused by the Varicella zoster virus and has absolutely no avian association. The disease features pruritic vesicular lesions on an erythematous base. The name likely stems from the French expression chiche-pois ("chickpea"), referencing the small, rounded appearance of the lesions.*
- *Erythema Toxicum Neonatorum: While "toxicum" conventionally suggests a condition caused by poisons or toxins, this neonatal eruption is entirely benign and self-limiting, hence it is nowadays known as erythema neonatorum. It is a common vesiculopustular rash affecting up to 50% of term neonates that resolves spontaneously within 1–2 weeks*



without treatment or residual effects.

- **Botryomycosis:** Named by Revolta in 1884 under the false impression of a fungal cause, the term draws from the Greek "Botrys" (a bunch of grapes). The suffix "-mycosis" is a misnomer, as the condition is actually a chronic granulomatous reaction primarily caused by the bacteria *Staphylococcus aureus*. It is now rightfully known as bacterial pseudomycosis or granular bacteriosis.
- **Impetigo Herpetiformis:** Used to represent generalized pustular psoriasis of pregnancy, this condition is neither infectious nor related to classical *Streptococci* or *Staphylococci* impetigo. The term originated simply because its pustular morphology mimicked an infectious dermatosis.
- **Trichomycosis:** Despite the "-mycosis" suffix suggesting a fungal etiology, this condition is caused by bacterial colonization of the hair shafts by *Corynebacterium* species. It is characterized by adherent concretions along the hair shafts. Trichobacteriosis has been advocated as a more scientifically appropriate nomenclature.
- **Eruptive Syringoma:** Traditionally classified as a benign eccrine adnexal neoplasm, emerging evidence indicates these lesions may represent a reactive hyperplastic proliferation of eccrine ducts triggered by underlying chronic inflammation. Consequently, "syringomatous dermatitis" has been proposed as a more accurate name.
- **Ringworm:** Contrary to its name, this condition is not caused by worms but by dermatophyte fungi involving keratinized tissues of the skin, hair, or nails. The misleading terminology originated from the characteristic annular, or ring-shaped, appearance of the lesions that historically resembled a worm-like pattern.
- **Sebaceous Cyst:** The majority of lesions labeled "sebaceous" are actually epidermal cyst, lined by stratified squamous epithelium and filled with keratinous debris rather than sebum. True cysts of sebaceous gland origin are distinctly uncommon and are accurately termed steatocytomas.
- **Acne Keloidalis:** Originally described by Pierre-Antoine-Ernest Bazin in 1872, this chronic scarring folliculitis presents as fibrotic papules and nodules over the nape of the neck and occipital scalp. It is pathogenically unrelated to *Acne vulgaris*, and the lesions do not represent true keloids histologically.

The stakes of medical misnomers extend beyond mere pedantry. Disease names heavily influence patient behavior—dictating whether they delay seeking care for a condition that sounds trivial, or trigger an unnecessary emergency presentation for one that sounds catastrophic. Contemporary dermatology has made significant efforts to replace archaic, misleading terminology with scientifically precise nomenclature based on etiology, histopathology, and molecular pathogenesis. Despite these advances, many traditional terms remain deeply entrenched in medical literature and routine clinical usage. Awareness of such misnomers is crucial for accurate clinical interpretation, effective academic communication, and improved teaching. Furthermore, appreciating the historical context behind these terms provides valuable insight into the evolution of dermatologic understanding, highlighting the progressive refinement of medical science over time.



CASE-PODIUM: PTCL-NOS (PERIPHERAL T CELL LYMPHOMA NOT OTHERWISE SPECIFIED)

Peripheral T-cell lymphoma not otherwise specified (PTCL-NOS), is a rare and aggressive mature T-cell neoplasm representing a heterogeneous group of nodal and extranodal T-cell lymphomas that do not fit into other defined entities in the current WHO classification. Cutaneous manifestations may occur either as primary skin disease or secondary involvement in systemic lymphoma and can often mimic common inflammatory dermatoses, creating significant diagnostic difficulty.

38-year-old male presented with recurrent episodes of generalized intensely pruritic erythematous to skin-colored papules for 9 months, associated with intermittent low-grade fever and episodic polyarthralgia. The lesions initially responded to systemic corticosteroids but relapsed repeatedly, with later development of pustular flare-ups and progressive worsening.

Cutaneous examination revealed multiple discrete papules predominantly over the extremities (Figure 1,2), along with involvement of the eyelids and inner canthus (Figure 3). General examination showed generalized lymphadenopathy and mild hepatosplenomegaly.

Dr. Saswati Halder
HOD, School of Tropical Medicine



Figure 1

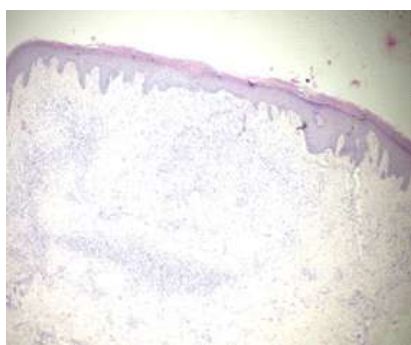


Figure 2



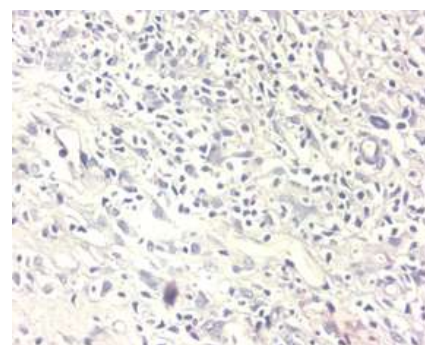
Figure 3

Laboratory investigations demonstrated marked leukocytosis with severe eosinophilia (60%), elevated serum IgE and LDH levels, and atypical lymphocytes in peripheral blood smear. Skin biopsy revealed dense dermal infiltrates of atypical lymphocytes with eosinophils.



10X

Epidermis: Focal parakeratosis, focal hypergranulosis, Mild acanthosis and spongiosis
Dermis: Dense, diffuse inflammatory infiltrate in upper and mid dermis

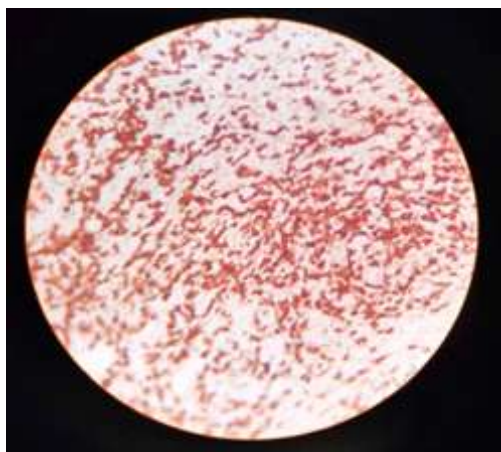


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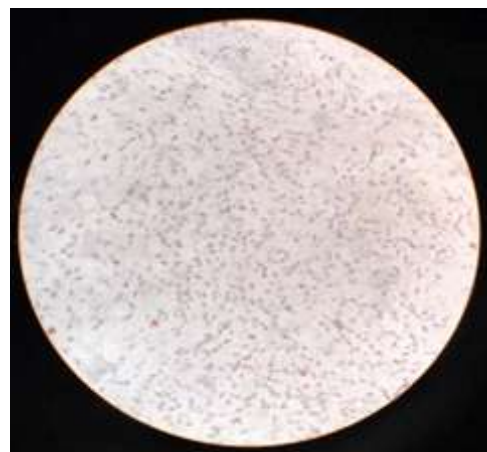
Dermis: Atypical lymphocyte and histiocytic infiltrate with occasional eosinophils



Lymph node biopsy showed effacement of nodal architecture by atypical lymphoid infiltrates with eosinophilic admixture. Immunohistochemistry and flow cytometry demonstrated an aberrant mature CD4-positive T-cell population expressing CD2, CD3, CD4, and CD5 with loss of CD7 and CD8 expression.



CD3 Positive



CD20 Negative

Bone marrow examination showed normoblastic maturation with relative eosinophilic hyperplasia without atypical cell infiltration. PET-CT revealed multiple FDG-avid lymph nodes without significant uptake in skin lesions.

After clinicopathological, immunophenotypic, and radiological correlation, a final diagnosis of Peripheral T-cell lymphoma, not otherwise specified (PTCL-NOS) with secondary cutaneous involvement and paraneoplastic eosinophilia was established.

Peripheral T-cell lymphoma not otherwise specified (PTCL-NOS), is an aggressive nature T cell lymphoma and is a diagnosis of exclusion that lacks defining clinical, histopathological, Immunohistochemical and immunophenotyping features of other T cell neoplasm or proliferation described as per current WHO classification 2022. It commonly presents with generalized lymphadenopathy, constitutional symptoms, extranodal involvement, and aggressive clinical behavior. Cutaneous involvement may occur secondarily and often presents with nonspecific lesions, posing a significant diagnostic challenge for dermatologists.

REFERENCES:

1. Campo E, Jaffe ES, Cook JR, et al. The International Consensus Classification of Mature Lymphoid Neoplasms: a report from the Clinical Advisory Committee. *Blood*. 2022.
2. Swerdlow SH, Campo E, Harris NL, et al. WHO Classification of Tumours of Haematolymphoid Tumours. 5th Edition. IARC; 2022.
3. Foss FM, Zinzani PL, Vose JM, et al. Peripheral T-cell lymphoma. *Blood*. 2011;117(25):6756–6767.
4. Willemze R, Cerroni L, Kempf W, et al. The 2018 update of the WHO-EORTC classification for primary cutaneous lymphomas. *Blood*. 2019;133(16):1703–1714.
5. Weinstock M, Reyngold M, Horwitz S. The evolving landscape of peripheral T-cell lymphoma. *Blood*. 2023.



Monthly Clinical Meeting of IADVL WB on 07/05/2026 at NRS Medical College & Hospital, Kolkata

On May 7th, 2026, the Department of Dermatology at NRS Medical College hosted the Monthly Clinical Meeting for the IADVL West Bengal State Branch. The session provided a formal academic forum for postgraduate trainees and senior faculty to review diverse clinical presentations and discuss comprehensive diagnostic evaluations.

The session was expertly chaired by Dr. Biswanath Naskar. The academic discourse was further enriched by the presence and clinical acumen of esteemed senior faculty members including Dr. Arun Achar (HOD Dermatology, NRS), Dr. Kingshuk Chatterjee, Dr. Sudip Kumar Ghosh, Dr. Kishalay Ghosh, Dr. Jayati Nandi, Dr. Abanti Saha. The presentations sparked robust interactive discussions, focusing on the intricate clinicopathological correlations required to manage these unique dermatoses.

The clinical docket featured the following presentations:

- Nodular Scleroderma presented by *Dr. Kundan Kumar Gupta*
- Systemic Amyloidosis presented by *Dr. Mahasweta Ghosh*
- Secondary Syphilis presented by *Dr. Monica Kumari*
- Langerhans Cell Histiocytosis (LCH) presented by *Dr. Sadia Rifat*
- Chromoblastomycosis presented by *Dr. Eshita Arora*
- Darier's Disease presented by *Dr. Mahormi Mazumder*
- Periumbilical Perforating PXE presented by *Dr. Sayoni Ghosh*
- Rhinosporidiosis presented by *Dr. Antara Mondal*





Webinar on DERMA Abahan: Season 2 Episode 1 on 16/05/2026 Autoimmune Bullous Diseases

On 16th May 2026, the IADVL West Bengal Academy, in academic collaboration with Ajanta Pharma under the banner of Derma Abahan – The Scientific Reckoner, successfully organized Season 2, Episode 1 on the topic “Autoimmune Bullous Diseases.” The webinar brought together renowned experts and academicians for an engaging and clinically enriching discussion focused on the diagnosis and management of autoimmune blistering disorders.

The evening commenced with a welcome address by the President of IADVL West Bengal, Dr. Arghyaprasun Ghosh, who emphasized the growing importance of structured academic discussions in improving the understanding and management of complex immunobullous diseases. The webinar was efficiently coordinated by Dr. Kaushiki Hazra, ensuring smooth execution and active academic interaction throughout the session.

The first academic session, “Diagnostic Approach in AIBD,” was delivered by Dr. Dipankar De. A few interesting clinical cases were discussed. The session systematically covered the role of Tzanck smear, histopathology, direct immunofluorescence (DIF), indirect immunofluorescence (IIF), ELISA, immunoblotting, immunoelectron microscopy, and multiplex bead assays in disease diagnosis and classification.

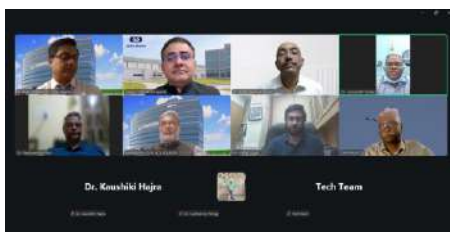
This was followed by an insightful lecture by Dr. Vishal Gupta on “Planning a Therapeutic Strategy in AIBDs.” The session focused on individualized treatment planning, balancing disease severity with long-term safety considerations, and tailoring therapy according to mucosal involvement, ocular disease, comorbidities, and treatment response. Newer treatment modalities, including FcRn antagonists, Bruton tyrosine kinase inhibitors, and CAAR-T cells, were also discussed.

The academic session culminated in an engaging panel discussion moderated by Dr. Vishal Gupta, with esteemed panelists Dr. Dipankar De, Dr. Raghavendra Rao, Dr. Arghyaprasun Ghosh, and Dr. Subhamoy Neogi. Detailed treatment protocols were discussed in the context of systemic comorbidities and tailoring of immunosuppressive therapy in patients with underlying infections such as tuberculosis. Furthermore, treatment options for a relapsed case of pemphigus previously treated with Rituximab were deliberated upon. The final case focused on the next step in the management of ocular pemphigus in a patient who demonstrated only mild improvement following Rituximab therapy.

The webinar concluded with remarks by the Academy Chair, Dr. Sumit Sen, who appreciated the scientific depth and practical relevance of the sessions.

The formal vote of thanks was delivered by the Honorary Secretary of IADVL West Bengal, Dr. Somenath Sarkar, acknowledging the contributions of the speakers, panelists, moderators, organizing team, and participants in making the academic event a grand success.

A total of 208 participants attended the webinar. Thank you all for your enthusiastic participation. Special thanks to Dr. Sumit Sen, Dr. Arghyaprasun Ghosh, and Dr. Sudip Ghosh for organizing such a wonderful programme. Special appreciation is also extended to Dr. Kishalay Ghosh for arranging this academic session. We hope to continue with the same enthusiasm in the future.



S2/M
2 months
Significantly painful oral erosions, genital erosions and watering of the eyes, minimal skin lesions
On semi-liquid diet, inadequate intake, 7 Kg weight loss in 2 months
Non-response to treatment from elsewhere: Prednisolone 30 mg/day tapered and MMF 506 mg twice a day

Severe / early relapsing cases?

- Retrospective series of 10 patients
- All received RTX (Lymphoma Protocol), after failing oral pred + ISA
- All achieved CR <=6 months
- ISA dose reduced after CR in 5 pts; stopped in the other 5 pts
 - MMF 250 mg/d; RTX 5 mg/wk, and dapsone 100 mg/d

RTX + low dose ISA (n=5)	RTX alone (n=5)
Relapse: 0/5 over a FU period of 61 (2-105) months	5/5 after 7 (5-9) months of stopping ISA

Sanjay M, Bhatia S, Jha S, Saha S, Ghoshal S, et al. Severe and/or relapsing treatment to response a sustained response in severe autoimmune bullous disease. *Journal of Cutaneous Medicine and Surgery*. 2018;14(10):1015-1018.



CME on Haircare Management Venue: JW Marriott, Kolkata | Date: 21st May 2026

An enriching and insightful Continuing Medical Education (CME) session was recently conducted by IADVL WB bringing together dermatologists and trainees for an in-depth exploration of hair loss—one of the most common yet challenging concerns in clinical practice.

The session commenced with a warm Welcome Address by our President, Dr. Arghyaprasun Ghosh, setting the tone for a day of academic excellence and collaborative learning.

Scientific Sessions included

- Dr. Dinesh Hawelia delivered a comprehensive lecture on “Exploring Pattern Hair Loss – Aetiopathogenesis & Diagnosis”, simplifying complex mechanisms and sharpening diagnostic acumen.
- Dr. Shrayan Pal presented an insightful talk on “Management of Female Alopecia”, highlighting practical approaches using oral, topical therapies, and nutraceuticals tailored to patient needs.
- Dr. Aniruddha Ghosh elaborated on “Surgical Management of Hair Loss”, offering valuable perspectives on procedural options and patient selection.

What made it special was the engaging interactive Q&A session, sparking meaningful discussions and delivering fresh insights for both students and practicing dermatologists.

We extend our heartfelt gratitude to our esteemed speakers and enthusiastic participants for making this CME a resounding success.

Together, we continue to learn, evolve, and elevate dermatological care.





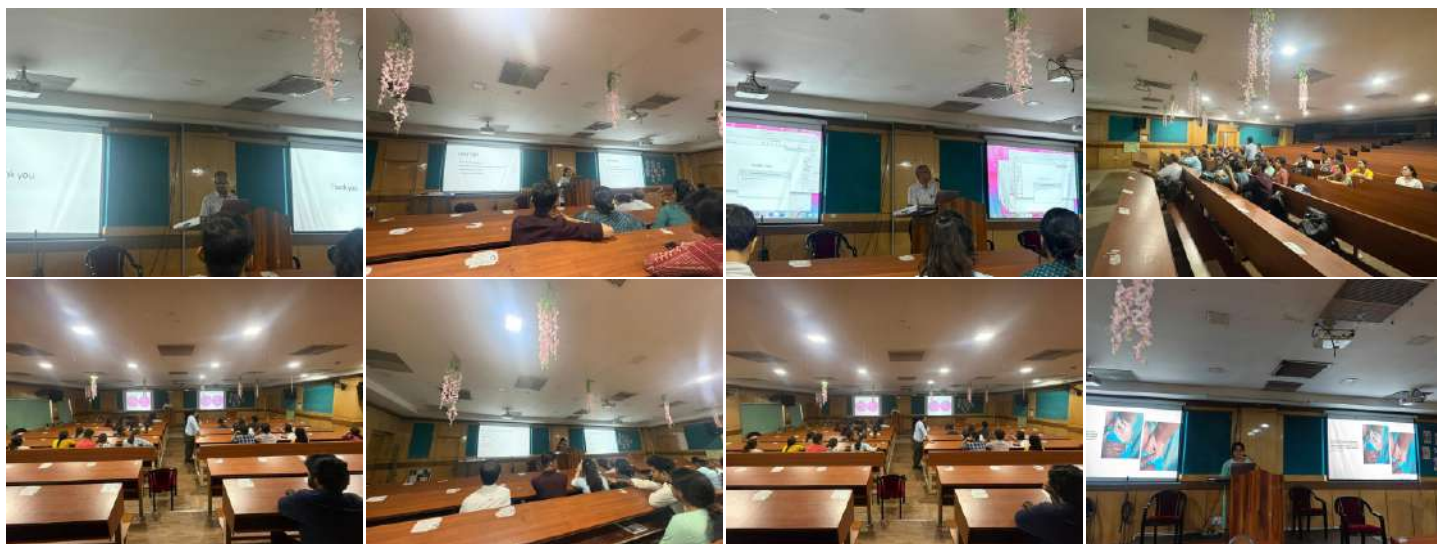
Monthly Clinical Meeting of IADVL WB on 28/05/2026 at Medical College & Hospital, Kolkata

The Department of Dermatology at Medical College Kolkata hosted the Monthly Clinical Meeting for the IADVL West Bengal State Branch. The event offered a valuable platform for trainees to delve into the diagnostic nuances, histopathological findings, and management strategies for a wide spectrum of cutaneous disorders.

The session was anchored by Prof. Dr. R.C. Gharami, Head of the Department of Dermatology at MCK, whose expert insights guided the academic discourse.

The following cases were presented and discussed throughout the meeting:

- *Histoid Hansen, Spiradenoma, and cutaneous anaplastic large cell lymphoma presented by* Dr. Saurav
- *Masson's Hemangioma and Sarcoidosis presented by* Dr. Disha
- *Angiolymphoid Hyperplasia with Eosinophilia and Eccrine Syringofibroadenoma presented by* Dr. Debarati
- *Hidradenoma and Malignant Peripheral Nerve Sheath Tumor presented by* Dr. Suptiparna
- *Extramammary Paget's Disease, Epidermolytic VEN, and Sebaceous Carcinoma presented by* Dr. Diganta
- *Solitary Mastocytoma presented by* Dr. Soubriti
- *BT Hansen and Papillon-Lefèvre Syndrome presented by* Dr. Moumita
- *Bowenoid Papulosis presented by* Dr. Banozир
- *Leiomyoma Cutis presented by* Dr. Ayushi
- *Hailey-Hailey Disease and Pigmented BCC presented by* Dr. Sneha





GURUBANI: Season 1 Episode 1, CME on Clinical Dermatology, on 30/05/2026 at School of Tropical Medicine, Kolkata

Embodying the timeless tradition of imparting wisdom from master to student, the Indian Association of Dermatologists, Venereologists & Leprologists (IADVL) West Bengal Academy hosted its inaugural CME event under the banner of GURU BANI. Held at the School of Tropical Medicine in Kolkata, this highly anticipated academic gathering provided an intensive afternoon dedicated entirely to Clinical Dermatology, living up to its profound motto: “Master the Science. Mentor the future.”

The session was formally introduced by Dr. Somenath Sarkar, Hony. Secretary, IADVL WB and Dr. Munmun Das Sarkar, Director, School of Tropical Medicine paving the way for focused expert lectures designed to tackle everyday clinical challenges.

The audience was enriched by deep dives into crucial topics, starting with practice essentials on drug eruption delivered by Dr. Indrashis Podder. This was followed by a comprehensive look at the diagnostic and therapeutic approaches to small vessel vasculitis explored by Dr. Sudip Kr. Ghosh. Concluding the didactic sessions, Dr. Nilendu Sarma presented a thorough and highly practical therapeutic approach to erythroderma.

Following each didactic lecture, an engaging audience question and answer session fostered active participation and vibrant academic exchange among attendees.

The event culminated in a case-based panel discussion focused on the approach and management of oral ulcers, effectively bridging the gap between theoretical knowledge and real-world clinical application.

The panel was moderated by Dr. Subhadeep Mallick and featured a formidable lineup of experts including Dr. Saswati Halder, Dr. Sudip Kr. Ghosh, Dr. Suchibrata Das, Dr. Somenath Sarkar, Dr. Maloy Pramanik and Dr. Dipra Biswas.

The inaugural GURU BANI masterclass concluded with a formal vote of thanks, marking the successful culmination of a meticulously curated academic experience that fortified the clinical foundations of attendees. The event, attended by 67 post graduate students and 10 faculty members, stood as a testament to IADVL WB Academy's commitment to advancing dermatological education through excellence, mentorship, and collaborative learning.





SKINTELLECT

The Official Newsletter of the IADVL West Bengal State Branch



Volume 4 Number 02
June 2026





DERMAGINATIONS: PAGING PASSION BEYOND PRACTICE

*Dr. Sabarna Samanta,
2nd Year PGT,
Dept of Dermatology, KPCMCH*



INSPIRED FROM
“THE STARRY NIGHT” BY VINCENT VAN GOGH
SUNFLOWER FIELDS





Derma Times

News, Trends & Developments

Zasocitinib (formerly TAK-279 or NDI-034858) is **a highly selective, oral, allosteric tyrosine kinase 2 (TYK2) inhibitor**. It is primarily researched for immune-mediated inflammatory conditions like plaque psoriasis, psoriatic arthritis, and Crohn's disease.

Key Highlights

- **Mechanism of Action:** Targets TYK2 to block core disease-driving immune pathways (such as IL-23, IL-12, and Type I interferons) without affecting other JAK family enzymes (JAK1, JAK2, and JAK3). It boasts over one-million-fold greater selectivity for TYK2 than other JAK enzymes, aiming for high efficacy with fewer off-target side effects.
- **Clinical Efficacy (Psoriasis):** Phase 3 trial results demonstrated rapid, deep, and durable skin clearance. At week 16, more than half of patients achieved 90% clearance (PASI 90), and roughly 30% achieved completely clear skin. Significant improvements over placebo were observed as early as week 4.
- **Current Status:** In late-stage development for moderate-to-severe plaque psoriasis and psoriatic arthritis. It is one of the most promising next-generation oral pills in the TYK2 inhibitor class, improving upon first-generation options like deucravacitinib by offering higher target affinity.

RCT: Tyrosine Kinase 2 Inhibition With Zasocitinib (TAK-279) in Psoriasis

POPULATION

177 Men, 82 Women



Adults with moderate to severe psoriasis for ≥ 6 mo covering $\geq 10\%$ of total body surface area

Mean (SD [range]) age, 47 (13 [18-70]) y

INTERVENTION

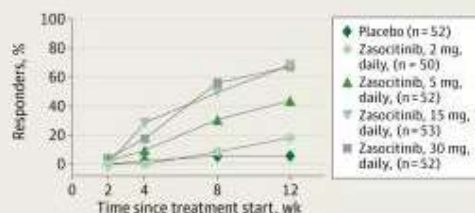
259 Patients randomized and analyzed



- 52 Placebo
Matching oral placebo
- 50 Zasocitinib, 2 mg, daily
- 52 Zasocitinib, 5 mg, daily
- 53 Zasocitinib, 15 mg, daily
- 52 Zasocitinib, 30 mg, daily

FINDINGS

PASI 75 response rates were statistically significantly greater among patients receiving zasocitinib 5, 15, or 30 mg, daily, than receiving placebo (all $P < .001$)



PASI 75 response rate

Placebo: 6%
 Zasocitinib, 2 mg: 18%, difference vs placebo: 12% (95% CI, 0-25; $P = .05$)
 Zasocitinib, 5 mg: 44%, difference vs placebo: 39% (95% CI, 24-53; $P < .001$)
 Zasocitinib, 15 mg: 68%, difference vs placebo: 62% (95% CI, 48-76; $P < .001$)
 Zasocitinib, 30 mg: 67%, difference vs placebo: 62% (95% CI, 47-76; $P < .001$)

SETTINGS / LOCATIONS



55 Sites in North America

PRIMARY OUTCOME

Proportion of patients achieving $\geq 75\%$ improvement in Psoriasis Area and Severity Index (PASI) score from baseline (PASI 75) to wk 12



Quiz Zone

1) A 14 year old was brought in with a blotchy red plaque on his forearm with a tendency to sweat excessively. Dermoscopy revealed the a specific pattern. Identify the condition connecting the images [fig 1].

2) X was a pioneering physician who is also the only dermatologist to have won the Nobel Prize till date. Identify X [fig 2].

3) Mr A presented with his daughter to the dermatology OPD. The daughter had multiple hyperpigmented macules and patches over her trunk, face and limbs and a few soft sub-cutaneous nodules over her trunk. When asked for any family history of such lesions, Mr.A showed us his palms [fig 3]. Identify the eponymous sign.

4) Study the characteristic histopathology image provided [fig 4] and identify the histopathological sign and associated disease.

5) Identify the clinical sign [fig 5]



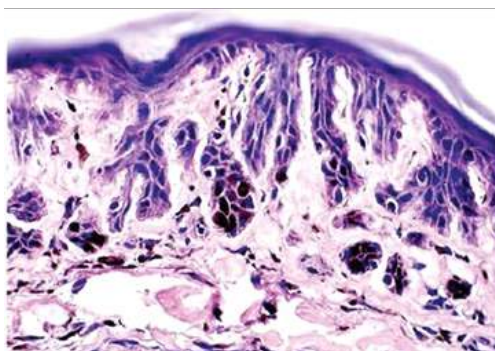
[fig 1]



[fig 2]



[fig 3]



[fig 4]



[fig 5]

The correct response given: Dr. Shatanik Bhattacharya for Dermwiz

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.



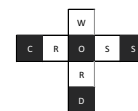
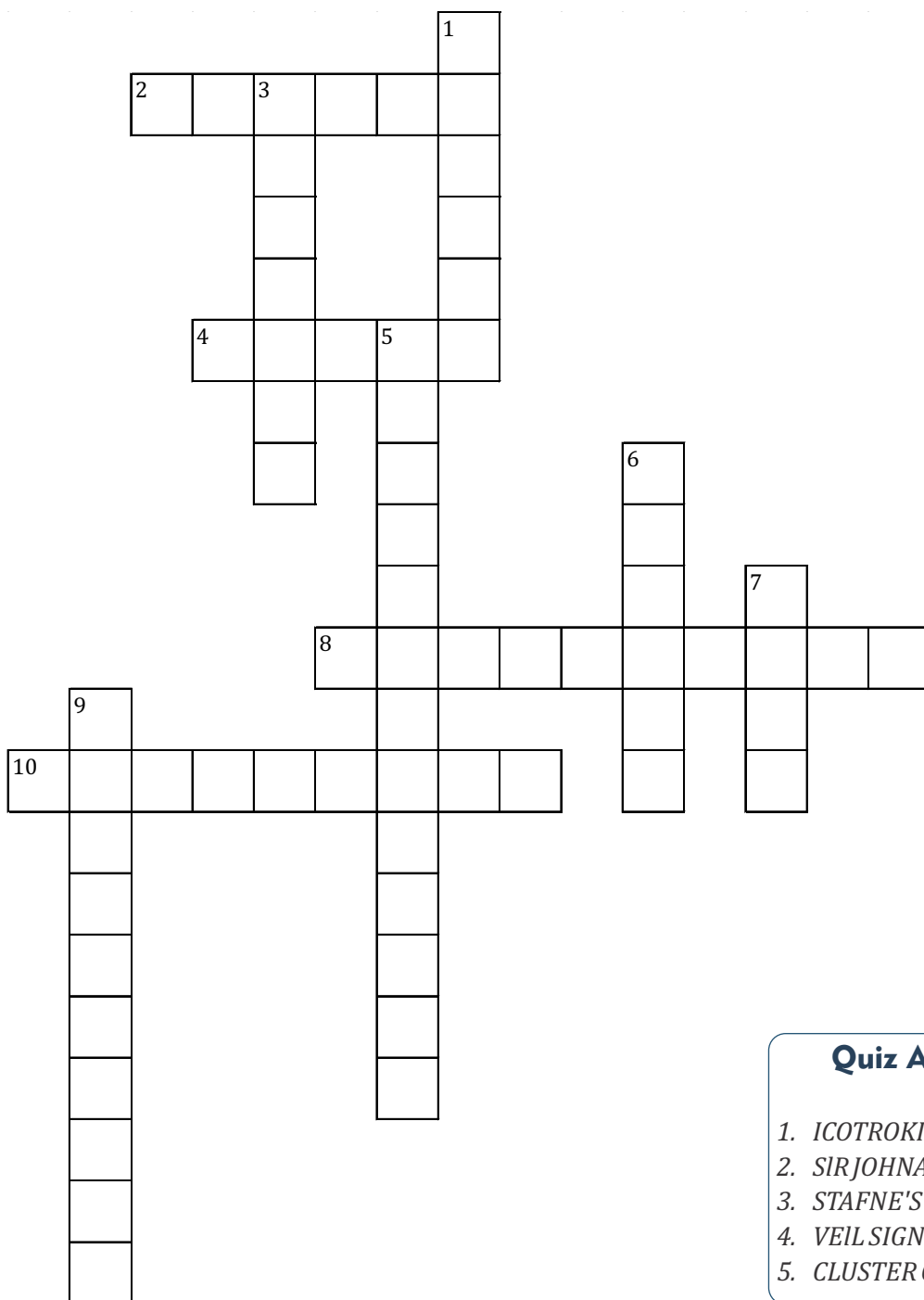
Brainstorm

Across

2. Syndrome with blepharochalasis, double upper lip and non toxic goitre
4. Colour of collagen when stained with Masson's trichrome
8. Latest approved topical agent for mild to moderate atopic dermatitis
10. Fill in the blank. Nevus sebaceous of _____?

Down

1. The first effective drug invented for leprosy
3. The name for (Adapalene 0.15% + Clindamycin 1.2% + Benzoyl peroxide 3.1%)
5. Histopathological term denoting a cell within a cell
6. Sign denoting ragged cuticle in Dermatomyositis.
7. Scoring tool for alopecia areata.
9. Early sign of ulnar nerve palsy



Quiz Answer Volume-4, Issue-1

1. ICOTROKINRA
2. SIRJOHNATHAN HUTCHINSON
3. STAFNE'S SIGN
4. VEIL SIGN
5. CLUSTER OF STARS SIGN, HAIRLESS GENE(hr)

Save
the
Date



14th Mid Term Conference

Experience and dynamicity shapes the future of Dermatology

27th & 28th June 2026

Venue

**Anticlock Suites & Resorts, Daldangamore
Bankura**

REGISTRATION FEES

Category	1/4/2026 30/4/2026	1/5/2026 10/6/2026	11/6/2026 On Spot
Life Member	₹ 1500/-	₹ 2500/-	₹ 3000/-
Accom Person	₹ 1000/-	₹ 2000/-	₹ 2500/-
PG Student	₹ 750/-	₹ 1500/-	₹ 2000/-
Cancellation	50%	25%	NIL

Programme Highlights

- Clinical dermatology
- Leprosy
- STI
- Aesthetics
- Award paper sessions and e poster for PGTs with prizes
- Free paper session for LMs & PGTs with prizes
- Young dermatologists' forum
- Quiz for PGTs

Scan to Register



www.iadvlwb.org

Save
the
Date



27th, 28th & 29th
November 2026
BBCC, Kolkata

DERMAZONE EAST

32nd East Zonal Conference
of IADVL



29th Annual State Conference
of IADVL WB Branch

CUTICON WB 2026

Theme:
NextGen Dermatology
Clinical Mastery Meets Innovation

Program Highlights

Aesthetic Dermatology
AI in Dermatology
Allergic Skin Disorders
Behavioural Patterns in STI
Clinicopathological Correlation
Dermatoeconomics

Dermatology & Internal Medicine
Dermato-Oncology
Emerging Cutaneous Infections
Geriatric Dermatology
Microbiome in Dermatology
Neglected Tropical Diseases

Pediatric Dermatology
Precision Medicine in Dermatology
Psychodermatology
Regenerative Medicine
Robotics in Dermatology
Therapeutic Updates