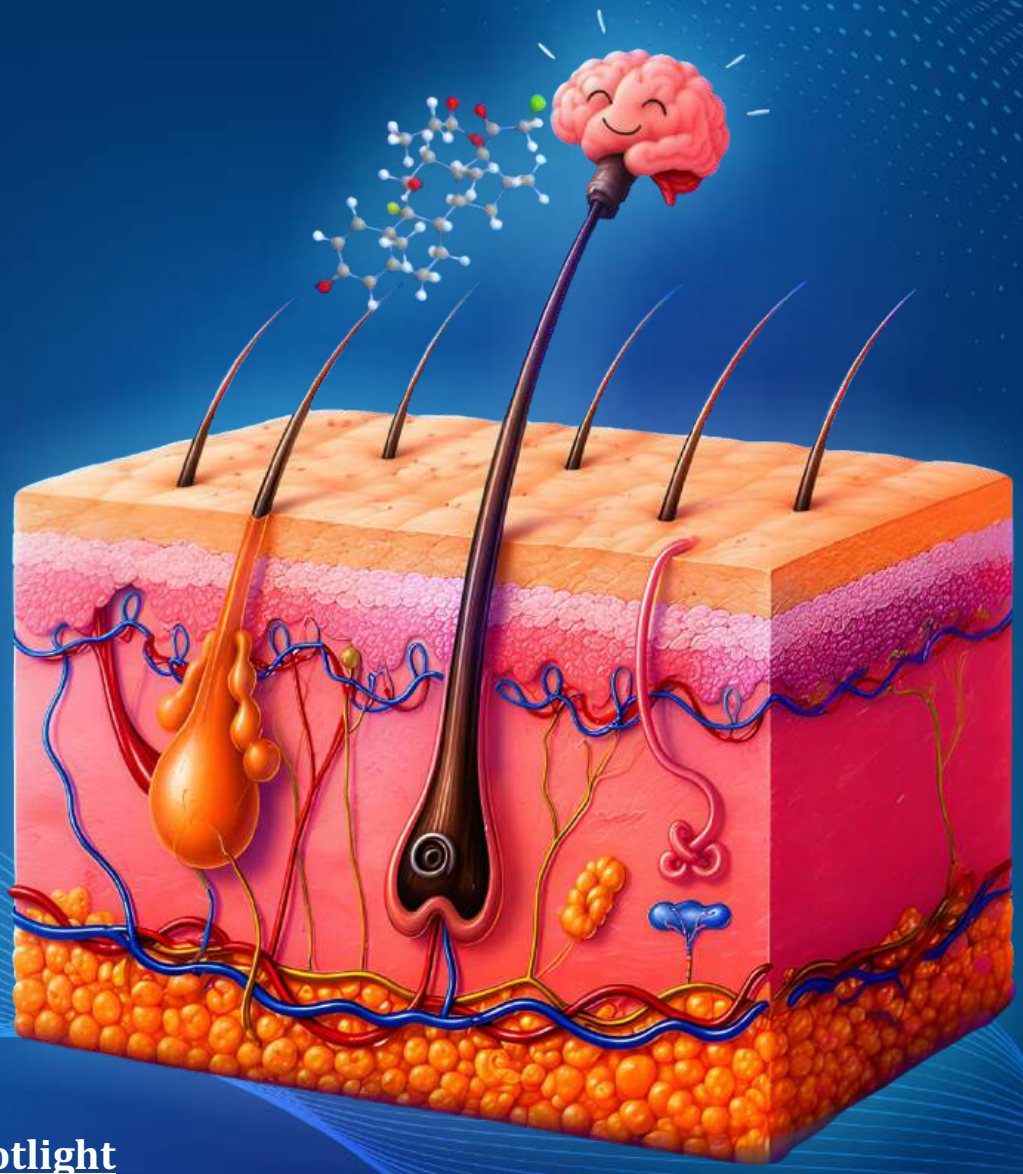
Indian Association of Dermatologists, Venereologists & Leprologists West Bengal State Branch

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.

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IADVL, WEST BENGAL STATE BRANCH
FLAT - 2E, 2ND FLOOR, MOON PLAZA
62, LENIN SARANI, KOLKATA - 700013
PH: +91 33 22277553

Compiled, Edited & Published by Hony. Secretary, on behalf of Indian Association of Dermatologists, Venereologists and Leprologists West Bengal State Branch

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Note from the President

Dear Esteemed Colleagues,

It is with great honour and privilege I assume the role of President of the Indian Association of Dermatologists Venereologists and Leprologists (IADVL), West Bengal State Branch for the year 2026-2027. I extend my sincere best wishes to each member and their family for their overall well-being.

I am profoundly conscious of the historic legacy into which this office inducts me. The outstanding leadership with which my illustrious predecessors have laid the academic and organizational blueprint has made my task that much easier and at the same time difficult to live up to it.

IADVL WB is a trendsetter in academic excellence and we hope to pursue that with the continuum of academic events lined up by our esteemed Academic Committee for the year ahead.

We are committed to community service in addition to the service we are already providing as doctors. The outreach to the designated population will continue with the active participation of our members with the same zeal and enthusiasm.

Dermatology is plagued by quackery which unfortunately could not be nipped in the bud. I urge all our members to report such occurrences coming their way to the anti-quackery cell.

It is our endeavour to induct young members as office bearers and other organizational and scientific posts who constitute the backbone to the future reverberant growth of our beloved association.

We have multiple WhatsApp groups which serve as excellent platform for exchange of scientific knowledge and ideas as well as pleasantries, time to time information regarding various scientific and social events, etc. It is my ardent appeal to our esteemed members to limit criticism on these groups to constructive ones which in no way should offend anyone personally or professionally. Neither the President nor the Hony. Secretary or any of the office bearers will be liable to deal with such unfortunate misadventures.

We are an ever-expanding family and my earnest appeal to all our esteemed members to make our association united and strong. Our office bearers including myself will always be there for everyone to solve their association related matters.

Let us together pledge to achieve greater heights for our beloved association.

My best wishes to all the members on শুভ নববর্ষ ১৪৩৩ (Happy Bengali New Year)

Long live IADVL.

Jai Hind.

With warm regards,

Dr. Arghyaprasun Ghosh
President
IADVL WB

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Secretary's Scribes

Dear Esteemed Members,

It gives me immense pleasure to welcome you to Skintellect, the official online newsletter of IADVL West Bengal. This initiative reflects our commitment to learning Dermatology, collaboration, and staying connected as a vibrant dermatology community.

In recent days knowledge is evolving rapidly. Skintellect aims to be a dynamic platform that brings together academic updates, clinical insights, research highlights, member achievements, insights from the juniors & seniors and activities of our state branch. Through this newsletter, we hope to strengthen our professional bonding, encourage exchange of ideas, and celebrate the remarkable work being done by our members across the state.

I warmly invite all members, seniors , young dermatologists, and postgraduate students, to actively contribute for this news letter .Your case reports, academic pearls, research updates, experiences, and creative inputs will make this newsletter more meaningful.

I must congratulate the entire team of Skintellect for their efforts to make this venture a successful one

Let Skintellect become not just a publication, but a shared voice of the Dermatologists of West Bengal.

With thanks and warm regards

Dr. Somenath Sarkar
Honorary Secretary
IADVL WB

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Editors Desk

Dear Readers

Greetings!

As the newly appointed Editor of Skintellect, it is both an honor and a privilege to be entrusted with the responsibility of carrying forward the legacy of this insightful and esteemed monthly newsletter of IADVL WB.

I would like to extend my heartfelt congratulations to Dr. Kaushiki Hazra for her outstanding contribution as Editor. I am also deeply grateful to her for introducing me to Skintellect. My sincere thanks to the respected Executive Committee of IADVL WB for their trust in me and for offering me this prestigious opportunity.

The purpose of this newsletter is to highlight the ongoing activities and achievements of our association, facilitate knowledge sharing among members, and encourage our younger colleagues to actively engage in the association's endeavors.

This year, the Skintellect team comprises seven members: Dr. Biswajoy Hore, Dr. Sambit Chatterjee, Dr. Shahruk Raza, Dr. Debargha Mukherjee, Dr. Srijani Debnath, Dr. Rubina Sultana, and Dr. Ananya Roy.

We are also excited to introduce a new segment titled "Case Podium", in addition to our existing features. This section will showcase interesting and challenging cases encountered in dermatological practice.

We sincerely hope that our members will enjoy the thoughtful and innovative content crafted each month and will wholeheartedly participate in making this new chapter of Skintellect a grand success, as always.

Warm Regards

Dr. Ameli Sarkar

Editor, Skintellect,

The IADVL WB Monthly Newsletter

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DERMATOLOGIST SPOTLIGHT: DR. APARESH CHANDRA PATRA

1. *Sir, it is an honour to have you with us. Could you share what inspired you to pursue dermatology and how your journey has evolved since then?*

   Thank you for this opportunity. While I was pursuing DLO I preferred reading Roxburg book of dermatology instead of my ENT textbook and I realised that I will be able to maintain good work life balance if I choose Dermatology.

2. *You have extensive experience in clinical dermatology. How important is clinical acumen in today's era of increasing reliance on investigations?*

   The foundation of high-quality patient care, combining theoretical expertise with practical experience to ensure accurate diagnosis, effective treatment depends on our clinical knowledge. I believe which investigation to go for can only be guided by the clinical acumen of a dermatologist.

3. *With the rapid rise of cosmetology and patient driven demands, have you encountered ethical dilemmas in practice? How to navigate in such situations?*

   YES, Key dilemmas include managing unrealistic client expectations.

   Proper counseling and gaining patients trust is the key to navigate in such a situation. Other than that prioritizing client safety, obtaining true informed consent and avoiding deceptive marketing

4. *Sir, could you share one particular challenging or memorable case from your career that significantly influenced your clinical perspective?*

   During the initial days of cyclosporine, I remember a case of lactating nursing staff with TEN admitted in a moribund condition. We treated her with syrup cyclosporine as she was unable to swallow any type of capsule and she responded. After few days she came to OPD for follow up with her neonate unrecognizable which brought immense joy to me.

5. *Sir, despite India achieving 'elimination' status, we continue to see new cases of leprosy. In your experience, what are the most common reasons for delayed or missed diagnosis today?*

   The social stigma which is attached to leprosy is still so persistent that even the family members are unwilling to entertain their own leprosy patients in the household and continue to be a major stumbling block in leprosy control measures. This leads to delayed diagnosis, treatment and late management of reactions leading to disabities.

   A better collaborative effort of grass root level health worker and specialist will play a crucial role in early diagnosis, treatment and prevention of disabilities.

6. *As a teacher who has mentored many dermatologists, what qualities do you believe distinguish an average resident from an exceptional one? How can post graduate trainees cultivate deeper clinical insight?*

   Hardwork, dedication and sincerity makes an average resident an exceptional one.

   In the era of cosmetology we teachers have a great responsibility to inculcate the essence of clinical dermatology. Regular case discussions, clinicopathological correlations and publications help a resident to develop better clinical insight.

7. *If you had an entire day free with no professional commitments, how would you ideally spend it? What advise would you give to young doctors on maintaining a healthy work-life balance while building their careers?*

   I like to spend my leisure time with my family.

   During early days of career it becomes difficult to balance everything but with time we have to adapt the art of maintaining healthy lifestyle with spending quality time with family, vacations and cultivating our hobbies which refreshes us for a new start again.

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DERMBUZZ :
FROM CURE TO CHALLENGE: THE ERA OF ANTIFUNGAL RESISTANCE

Dr. Anirban Mukherjee
Senior resident
Chandannagar SDH

Once Alexander Fleming said, "The time may come when penicillin can be bought by anyone in the shops. Then there is the danger that the ignorant man may easily under-dose himself and by exposing his microbes to non-lethal quantities of the drug make them resistant". Though the above context is antibacterial resistance, in a similar way, isn't it applicable in antifungal resistance too?

Exposure to antifungal drug is a kind of threat to the existence of fungi. To survive, it must develop alternate methods and bypass systems to avoid the toxic effects of these drugs. Development of resistance against specific drugs is an adaptive response in any organism. Fungi are also not out of this thumb rule. Although it is a challenge to the human beings, it is a weapon in the 'struggle for existence' of fungi.

So, the fungal diseases, once easily curable, have become challenging for the dermatologists and physicians in a significant number of cases, and unfortunately, the number is gradually uprising. The scenario has become a form of slow epidemic.

Types of antifungal resistance

Clinical resistance is defined as failure to eradicate a fungal infection despite the administration of an antifungal agent with in vitro activity against the organism.

Microbiological resistance is non-susceptibility of a fungus to an antifungal agent by in vitro susceptibility testing, in which the minimum inhibitory concentration (MIC) of the drug exceeds the susceptibility breakpoint for that organism. It can be subdivided into 2 groups –

1. *Primary: Fungi are resistant to the drugs before exposure*
2. *Secondary/acquired: Resistance develops after the exposure to antifungal drugs*

Tolerance versus resistance

Antifungal tolerance refers to the ability of a subpopulation of fungal cells to survive and proliferate in the presence of antifungal agents at concentrations exceeding the established MIC. It is often confused with antifungal resistance. But, there are subtle differences between these entities. Tolerance is often transient response, whereas resistance is often permanent and heritable. Tolerance is often mediated by epigenetic and phenotypical changes; on the other hand, resistance occurs through specific genetic alterations. Clinically, tolerance can be distinguished from the primary resistance, but it becomes difficult to differentiate from the secondary resistance. Tolerant strains initially respond to antifungal therapy but experience a resurgence of symptoms or persistent infection despite appropriate drug levels.

The epidemiological triad – interaction between fungi, host and environment

It is a battle between the fungi and the human host, where the environment plays a significant role like a catalyst. Multiple factors determine the development and persistence of fungal disease resistant to conventional drugs. The fungi have developed several mechanisms to evade the effects of the drugs like increased production of efflux pumps, mutations causing diminished affinity towards the drug target, biofilm formation, stress adaptation etc. The host factors that are important for development of resistance are immunosuppression, site of involvement, late onset of treatment, poor compliance, involvement of other family members, financial issue etc. Commonly responsible environmental factors are high humidity with temperature, usage of azole-based fungicides in grape and cereal production etc.

T. indotineae has been reported in about 40 countries of south Asia, north and south America, Oceania and parts of Europe. It surpassed T. rubrum between 2017 and 2020 as the dominant strain in India, with multi-drug resistance giving the competitive benefit.

Molecular mechanisms – its role behind the curtain

Genetic mechanisms of resistance are point mutations, gene duplication, aneuploidy, transposon, loss of heterozygosity, hypermutator lineage etc. Epigenetic mechanisms are histone modification, DNA methylation and chromatin remodelling. Phenotypical alterations like biofilm formation, persister fungi and stress response activation also play significant role.

Upregulation or overexpression of the genes encoding the efflux pumps belonging to ATP-binding cassette (ABC) superfamily and the major facilitator superfamily (MFS). Amino acid substitution in the squalene epoxidase(ERG1) gene makes fungi less susceptible to terbinafine. Point mutation in the ERG11 gene that codes for lanosterol 14α-demethylase reduces the binding capacity of the azole drug to its target.

Alteration in the late steps of the ergosterol biosynthetic pathway through inactivation of the ERG3 gene can lead to the total inactivation of C5 sterol desaturase and also can give rise to cross-resistance to all azole drugs.

Mucoromycota and Lomentospora spp. have unique cell wall structures that limit the penetration and action of azole antifungals, thereby contributing to their intrinsic resistance. Candida albicans, Candida glabrata, Aspergillus sp., etc. are capable of producing biofilms that exist in a sessile, multicellular state and produce an extracellular matrix that protects them from antifungal agents. Few yeasts and filamentous fungi are able to grow in elevated echinocandin concentrations much higher than the MICs – this is called ***paradoxical effect or "eagle effect,"*** *is due to the upregulation of the chitin synthesis in the fungal cell wall after drug administration.*

Clinical indicators of resistant dermatophytosis

History and clinical examination often provide clue to drug-resistant mycosis. In history, there is resurgence of symptoms after stopping or lack of improvement with the first-line antifungal drugs like itraconazole. Patient often consult dermatologist after visiting non-medicos and using topical steroids. On examination, there may be multiple concentric rings or unusual morphologies resembling eczema. Folliculitis and adverse effects of topical steroids may complicate the picture. Multisite involvement has become common in many patients. Sometimes, facial involvement becomes too atypical to diagnose.

Diagnosis

Dermatophyte, candida and other fungal skin infections are usually diagnosed by history taking and clinical examination. Clinical diagnosis sometimes becomes difficult because of atypical morphology, commonly due to steroid application. Such cases can be diagnosed by KOH mount, histopathology and culture. But, these methods can not differentiate T.indotineae from closely related T.mentagrophytes complex. Internal transcribed spacer (ITS) sequencing is the gold standard for diagnosis of T.indotineae. However, in some cases, variations of the ITS region of T.mentagrophytes and T.interdigitale is highly similar to T.indotineae. So, the other methods that can increase the specificity of diagnosis of T.indotineae are Translation elongation factor 1-α (TEF1-α) sequencing, Matrix-assisted laser desorption/ionization time of flight mass spectrometry (MALDI-TOF MS), qPCR/real-time PCR etc.

Conventional treatment options

The commonly used drugs in fungal skin infections are azole group and allylamines –

Topical: miconazole, ketoconazole, clotrimazole, eberconazole, luliconazole, oxiconazole, terbinafine, naftifine etc.

Systemic: Fluconazole, itraconazole, terbinafine etc.

How to win the race: Newer agents and recent advances

Topical: Keratolytics like salicylic acid (3-6%) or urea-based creams/ointments along with antifungal agents can be used in hyperkeratotic areas (like palms and soles) in dermatophytosis. Topical antifungals need to be used 2 cm beyond the

visible margin and 2 weeks beyond cure. Some less commonly used agents like tioconazole nail solution, efinaconazole, bifonazole, Whitfield's ointment, undecenoates, tolnaftate, tavaborole may be tried in resistant cases.

Systemic: Voriconazole, posaconazole, isavuconazole, fosravuconazole are newer azole antifungals that may be used in resistant fungal diseases. Super-bioavailable itraconazole has several advantages like predictable bioavailability, less dependence on gastric pH and no interaction with PPI/H2 blockers, over the conventional one. Once-daily oral fluconazole is another strategy in resistant dermatophytosis. Griseofulvin may also be used in some cases. Higher doses of itraconazole (200 mg BD) and terbinafine (250 mg BD) may also be tried. USFDA approved novel antifungals for vulvovaginal candidiasis are ibrexafungerp (Triterprenoid & glucan synthase inhibitor) and oteseconazole (CYP51 inhibitor with high slectivity for fungal enzymes). Rezafungin (next generation echinocandin- once weekly injection) has been approved for invasive candidiasis and candidemia. Liposomal amphotericin B remains the last option for multidrug resistant fungi. The antifungals in phase 3 trials are olorofim (novel orotomide targeting dihydroorotate dehydrogenase), fosmanogepix (gwt1 enzyme inhibitor, preventing the fungus from anchoring proteins to its cell wall) and encochelated amphotericin B. Combination of systemic and topical antifungals or two systemic agents may be an effective weapon; but the drawbacks are heightened toxicity, increased drug interactions, more cost, and poorly standardized methods of testing efficacy of the combination.

Non-antifungal drugs: Some non-antifungal drugs can act against the fungi. Statins are active against M. canis and T. mentagrophytes. Ciclosporine increases susceptibility to fluconazole due to efflux pump deletion or alteration of stress response. Such drugs may be used in conjunction with the antifungals.

Antifungal Stewardship: This programme has been started by WHO to combat the battle of antimicrobial drug resistance drug resistance. To counteract the emergence of drug-resistant fungi, strict adherence to such programme will help us maintain effective treatment options by reducing antifungal misuse and minimising adverse effects.

What can we expect in coming decades?

Multiple clinical trials, systemic reviews and meta-analyses should be carried out to develop newer cost-effective efficacious antifungal drugs with few adverse effects. Governmental policies and acts are required to restrict the purchase of over-the-counter topical steroids and to take appropriate actions against the quacks. We should look forward with the rays of hope.

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RESIDENT'S CORNER:
THE ANTIOXIDANT EDGE: REWRITING THE RULES OF SKIN AGING AND BEYOND

Dr. Smriti Pal
1st Year, PGT,
RG Kar MCH, Kolkata

The quest for youthful skin has moved beyond simple moisturisation to a deep, molecular understanding of how the body ages. Emerging scientific research identifies oxidative stress as the primary culprit behind visible skin ageing.

Reactive oxygen species (ROS) induce molecular damage to DNA, proteins, and lipids, accelerating cutaneous aging and contributing to pigmentary disorders, inflammation, and carcinogenesis. Fortunately, Antioxidants—both endogenous and exogenous—have emerged as critical modulators in mitigating oxidative stress and restoring skin homeostasis. Published studies highlight antioxidants as a critical defense, capable of not just protecting the skin but actively stimulating its natural repair processes.

This review focuses on the role of antioxidants in skin aging, explores emerging therapeutic strategies, and highlights their expanding role beyond traditional anti-aging paradigms.

Introduction

The skin, as the largest organ of the body, is continuously exposed to environmental insults such as ultraviolet (UV) radiation, pollution, and toxins. These exposures generate ROS, leading to oxidative stress which is a key driver of premature skin aging (photoaging). Traditional anti-aging strategies have focused on symptomatic correction. However, antioxidants have emerged as a valuable tool in the dermatologist's arsenal that can target oxidative stress at a molecular level virtually leading to reverse ageing of skin.

Skin ageing is a complex process that is driven by genetics and external factors together. Intrinsic ageing is a natural process and is dependent on the genetics of the individual. It leads to thinning of the epidermis, reduced collagen synthesis, decreased fibroblast activity, appearance of fine wrinkles and dryness as one ages. On the other hand, ***Extrinsic Aging*** *(Photoaging) is primarily driven by UV radiation and environmental factors. It leads to increased ROS generation which cause Matrix metalloproteinase (MMP) activation therefore leads to degradation of collagen, elastin, activation of inflammatory pathways and pigmentary changes. ROS can also cause DNA mutation, membrane instability by lipid oxidation and enzyme dysfunction. Overwhelming exposure to extrinsic factors in today's day and age can lead to premature ageing of skin, inflammation and in some cases tumor progression.*

Antioxidant Defense*: The skin possesses an endogenous antioxidant system (e.g., superoxide dismutase, catalase, Glutathione peroxidase). However, research shows these levels decline significantly with age—vitamin C and glutathione levels can drop by 40–60% in elderly skin.*

Published clinical trials have identified several "gold standard" Exogenous antioxidants that effectively mitigate the effects of ROS when applied topically or consumed via diet.

1. Vitamin C (L-Ascorbic Acid)

Clinical studies demonstrate that topical vitamin C (in concentrations of 5–15%) induces the production of type I and type III collagen. A split-face study on 55 women showed that a serum containing vitamin C and E significantly improved smoothness, elasticity, and radiance over two months.

Key Benefit: Brightens skin tone and repairs signs of photoageing.

2. Vitamin E (α-Tocopherol)

Vitamin E is the most prominent lipid-soluble antioxidant in the skin. It scavenges lipid peroxyl radicals to protect cell membranes. Promotes cell turnover, increase collagen production, reduce fine wrinkles.

Synergy: Research consistently proves that the combination of vitamins C and E is more effective than either alone, as vitamin C helps regenerate oxidized vitamin E.

3. Vitamin A (Retinoids)

While often known for cell turnover, retinol acts as a potent antioxidant that stimulates fibroblasts to produce collagen and inhibits MMP activity. Clinical studies suggest that consistent use of 0.1% retinol for 3–6 months significantly reduces wrinkles.

4. Coenzyme Q10 (CoQ10)

CoQ10 protects keratinocytes from UVA-induced oxidative stress and helps maintain mitochondrial function. Studies show it can prevent photoageing and enhance skin renewal.

5. Carotenoids: Supplements like lycopene (from tomatoes) and astaxanthin have demonstrated the ability to increase the skin's baseline UV protection, reducing sensitivity to sunburn.

6. Polyphenols (e.g., Green Tea Extract) are Anti-inflammatory and anti-carcinogenic. They inhibit UV-induced damage.

7. Niacinamide Improves barrier function, reduces oxidative stress, has anti-inflammatory and depigmenting effects.

Antioxidants in Photoprotection: Antioxidants complement sunscreens by Neutralizing UV-induced ROS, Reducing DNA damage, Preventing immunosuppression. However, they are not substitutes but adjuncts to photoprotection. Antioxidants can be delivered Topicallly and Systemically. Emerging evidence supports synergistic use of topical + systemic antioxidants for optimal outcomes.

***Uses Beyond Aging**: Expanded Roles of Antioxidants: in **Pigmentary Disorders** like Melasma, Post-inflammatory hyperpigmentation they act by inhibition of tyrosinase and oxidative pathways.*

***In Inflammatory Skin Diseases**, like Acne vulgaris, Atopic dermatitis, Psoriasis Antioxidants reduce inflammatory cytokines and oxidative burden. They also **Prevent Skin Cancer** by reduction in UV-induced DNA mutations and protection againstphotocarcinogenesis. Antioxidants cause **Wound Healing** by promoting fibroblast proliferation and enhanced collagen deposition.*

***Emerging Trends in Antioxidant Therapy**: Nanotechnology-Based Delivery (Liposomes, nanoparticles) directly to lesions leading to improved stability, bioavailability and lower toxicity. Cerium oxide, manganese-based, and gold nanoparticles are being used for their intrinsic enzyme-mimicking (SOD or catalase-like) properties, which scavenge reactive oxygen species (ROS).*

Targeted Therapy: Instead of broad scavenging, new strategies target specific sites of oxidative stress, such as mitochondria (using MitoQ) or specific inflammatory microenvironments. Increased focus on Plant-Based and Natural Antioxidants (Resveratrol, Curcumin, Flavonoids) .

***Limitations and Challenges**: Antioxidant therapy faces significant challenges, including poor bioavailability, lack of tissue-specific targeting, and inconsistent clinical trial results, despite showing promise in preclinical studies. Research is sometimes limited by the use of poorly validated assays that do not accurately measure antioxidant efficacy in vivo. Doses required for efficacy often lead to safety concerns, such as potential pro-oxidant effects, while the complex, interconnected nature of oxidative stress makes targeting specific reactive oxygen species (ROS) difficult.*

The future of Antioxidants seems to be moving towards Personalized antioxidant therapy based on genetic profiling. Combining formulations to target multiple pathways at once and its integration with regenerative dermatology.

Antioxidants represent a paradigm shift in dermatology—from reactive treatment to proactive prevention. By targeting oxidative stress, they not only delay skin aging but also address a spectrum of dermatological conditions. Future research should focus on optimizing delivery systems, improving bioavailability, and establishing standardized clinical protocols.

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CASE-PODIUM: BATHING SUIT NEVUS

Dr. Sujata Sengupta
Prof. & HOD, Dept of DVL, KPC MCH, Kolkata

Giant Congenital Melanocytic nevus are large macular lesions with a diameter of more than 20 cm[1]. Bathing Suit Nevi are a subgroup of giant congenital melanocytic nevus . They are usually present from birth and gradually develop terminal hair over a period of time . Most common location includes the buttocks , groin and thighs[2] . Primarily it occurs due to post-zygotic genetic mutations which are usually not inherited directly from parents and are sporadic in nature .

A 3 day old neonate , born to non-consanguineous parents by normal vaginal delivery with an uneventful antenatal history presented with a pigmented patch involving the trunk , limbs and face since birth . There was no history of any neurological symptoms like seizures and no family history of any such similar condition . General physical examination was within normal limits . Cutaneous examination revealed a black coloured patch which covered the entire trunk , groin and buttocks extending onto the lower limbs . There was also patchy involvement of the scalp . Hypertrichosis was seen over the lesion on the back . Some satellite lesions were also observed on both the legs extending from the lesion on the thighs . No mucosal involvement was noted . No changes were seen as far as hair and nails were concerned . Other radiological investigations ranging from chest X-Ray to X-ray spine as well as CT and MRI brain were all within normal limits . Biopsy could not be done . A clinical diagnosis of Bathing Suit Nevus was made . The parents were counselled regarding the condition and the associated risks . Periodic follow ups were recommended for observation .

Bathing Suit Nevus is usually present at birth or develops shortly after birth . It is caused by proliferation of melanocytes . There can sometimes be hypertrichosis associated with it . Apart from cosmetic concerns , increased risk of melanoma is seen in association with it . The risk varies between 2 and 10% depending on the size of the nevus . Neurological involvement is often seen . Lesions found over the cervical region can be associated with leptomeningeal melanocytosis causing seizures and hydrocephalus with high morality rates[3] . Multiple nevi more than 50 in number or presence of satellite nevi can sometimes raise the chances of malignant transformation . Prenatal diagnosis is not possible as mutation is sporadic and mossaic . These patients need to be followed up regularly and closely observed . Treatment options include stage wise excision along with grafting . Dermabrasion , Q-switched laser and cultured epithelial autografts have also been tried with limited success .

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Dermatology Brush Up 4.0
on 3/04/2026 at IPGMER & SSKM Hospital, Kolkata

THE BLUEPRINT FOR EXCELLENCE: IPGMER HOSTS BRUSH UP 4.0

Navigating the vast and ever-evolving landscape of dermatology can be an overwhelming experience for residents, particularly with final examinations approaching. Brush Up 4.0, a premier academic initiative under the banner of IADVL, was thoughtfully designed to address this challenge—helping students consolidate high-yield topics, refine clinical acumen, and master the art of case presentation. Hosted for the first time at IPGMER & SSKM Hospital, the event stood as a testament to academic rigor and collaborative learning.

The program commenced with lamp-lighting ceremony, graced by eminent dignitaries including IADVL West Bengal President Dr. Arghyaprasun Ghosh, Dr. Kakali Mridha, Dr. Sujata Sengupta and Dr. Saumya Panda. Their presence, coupled with inspiring inaugural remarks by Dr.Arghyaprasun Ghosh, set a scholarly and enthusiastic tone for the day.

What truly distinguished Brush Up 4.0 was its structured, examination-oriented, and highly practical approach. Moving beyond conventional didactic teaching, each case presentation was meticulously aligned with exam expectations and followed by insightful, faculty-led discussions that emphasized clinical reasoning and precision.The pre-lunch sessions focused on case-based learning. The opening session on genital ulcers, presented by IPGMER, was guided by Dr. Sujata Sengupta and Dr. Saumya Panda, with a strong emphasis on systematic evaluation, differential diagnosis, and management strategies. This was followed by a case on Hansen disease presented by RG Kar Medical College under the guidance of Dr. Nilay Kanti Das and Dr. Somenath Sarkar, offering a nuanced understanding of history-taking and clinical examination and management.

Subsequently, a case on autoimmune bullous diseases presented by KPC Medical College was expertly discussed by Dr. Arghyaprasun Ghosh and Dr. Arun Achar, who highlighted structured approaches to tackling complex scenarios in examinations. The morning session concluded with autoimmune connective tissue disorders, presented by Bankura Sammilani Medical College and guided by Dr. Sudip Kumar Ghosh and Dr. Suchibrata Das, focusing on subtle clinical cues and examiner expectations.

The post-lunch segment transitioned into a more dynamic and engaging format. The "Spotters" round, conducted under the keen supervision of Dr. Anupam Das, Dr. Partha Mukhopadhyay, and Dr. Indrashis Podder, challenged the 3rd year residents of NRS Medical college, Burdwan Medical college and JIMS to think swiftly and respond with accuracy, closely simulating real examination pressure.

Attention then shifted to crucial ancillary domains. The Instruments and Drugs session, conducted by Dr. Aniruddha Ghosh and Dr. Kingshuk Chatterjee questioned the 3rd year residents of School of Tropical Medicine reinforcing key concepts in dermatological therapeutics and procedural tools.

The "Flying Viva" session followed, designed to replicate the intensity and unpredictability of the MD practical examinations. Led by experienced examiners including Dr. Abanti Saha, Dr. Kakali Mridha, and Dr. Ramesh Chandra Gharami, this rapid-fire session exposed the residents to a wide spectrum of questioning styles, thereby improving adaptability, confidence, and composure under pressure.The subsequent Histopathology session, conducted by Dr. Sisir Das and Dr. Aparajita Ghosh offered a comprehensive and lucid review of microscopic dermatology.

The event concluded with a valedictory session, marking the successful culmination of a meticulously curated academic experience. Drawing an impressive turnout of 118 participants, the event turned out to be a resounding success, fostering a vibrant environment of scholarly exchange.Brush Up 4.0 not only served as a robust revision platform but also nurtured critical thinking, clinical reasoning, and effective presentation skills. It was, without doubt, an enriching and intellectually stimulating experience that left participants better prepared, more confident, and inspired to strive for excellence



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Master Class: Lasers in Dermatology, Season:1-Episode:4 on 5/04/2026 at The Sonnet, Salt Lake, Kolkata

When science meets skill, great clinical outcomes follow...this philosophy was at the heart of the Master Class – Season 1, Episode 4 by the Indian Association of Dermatologists, Venereologists,Leprologists West Bengal Academy. Held on April 5, 2026, at The Sonnet, Salt Lake, the event offered an insight-driven deep dive into the real-world application of lasers in dermatology, marking a significant step into the future of aesthetic practice.

Moving beyond conventional continuing medical education (CME), this symposium was meticulously structured to bridge the gap between textbook theory and practical execution. Whether attendees were just establishing their practice or looking to scale up their clinics, the session was thoughtfully curated to provide clarity, confidence, and a distinct clinical edge. The curriculum commenced with a strong foundation in laser physics, systematically simplifying complex concepts for immediate clinical use.

What truly distinguished this Master Class was its unwavering focus on real-world applicability. Sessions covered robust practical protocols, emphasizing techniques ranging from laser hair reduction to the nuances of utilizing Q-switched Nd:YAG lasers and beyond. Furthermore, the program facilitated honest, much-needed conversations regarding complications, realistic patient outcomes, and managing expectations. Attention was also given to practice management, with experts sharing invaluable insights for establishing and optimizing laser setups, from budget-conscious clinics to premium aesthetic spaces.

The academic discourse was elevated by the presence of stalwarts in the field, including Dr. Dinesh Hawelia, Dr. Somodyuti Chandra, Dr. Abhishek De, Dr. Nidhi Jindal, and Dr. Shreya Poddar. Their collective expertise culminated in a dynamic expert panel discussion, offering practice-changing insights, clinical pearls, and nuanced guidance that standard textbooks often overlook.

Attended by 38 participants, the event proved to be a highly successful endeavour that drove meaningful and high yield discussions.

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Webinar on AIBD
on 25/04/2026 at online platform

On 25th April 2026, the IADVL West Bengal Academy, in academic partnership with Indchemie health specialities, successfully organized a webinar on Autoimmune Bullous Diseases, bringing together experts to discuss recent advances in this challenging domain.

The session commenced with a welcome address and an insightful introduction by veteran dermatologist Dr. Sumit Sen.

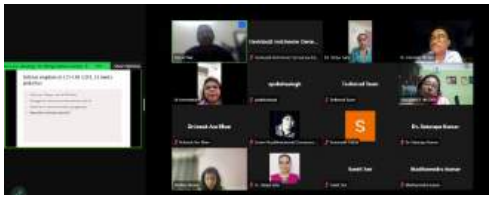
Setting the academic tone, Dr. Ismat Ara Khan delivered the first lecture on "Recent Advances in Innate Immune Cells of Bullous Pemphigoid" offering a comprehensive overview of the evolving understanding of the disease's pathogenesis.

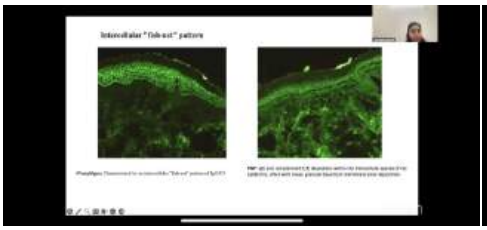
This was followed by Dr. Apeksha Singh, who presented on "Advanced Diagnostic Techniques in Autoimmune Bullous Diseases" highlighting the latest developments in diagnostic modalities and their clinical relevance.

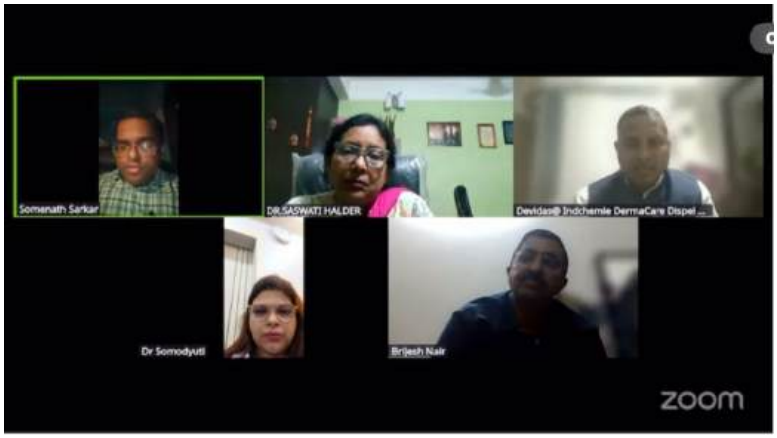
The third talk, "Advances in Management: Biologics & Targeted Therapies in Autoimmune Bullous Disorders" was delivered by Dr. Satarupa Kumar, focusing on emerging therapeutic strategies and modern treatment approaches that are shaping current clinical practice.

The academic session transitioned into an engaging panel discussion on case-based management of difficult scenarios in autoimmune bullous diseases. The session was ably moderated by Dr. Shriya Saha, with esteemed panelists Dr. Saswati Halder, , Dr. Brijesh Nair, Dr. Debalina Bhunia, Dr. Indrashis Podder and Dr. Somodyuti Chandra who shared practical insights on isolated erosive stomatitis, latent tuberculosis screening in a case of Bullous pemphigoid , extensive Pemphigus foliaceus, Pemphigoid gestationis, and relapsed Pemphigus Vulgaris after Rituximab, with emphasis on evidence-based use of biologics and disease monitoring.

The event concluded with a heartfelt vote of thanks delivered by the Honorary Secretary of IADVL West Bengal, Dr. Somenath Sarkar.

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DERMAGINATIONS:
PAGING PASSION BEYOND PRACTICE

NAME.- SILENT OVERFLOW.
MEDIUM - GRAPHITE PENCIL

Dr. Arka Pramanik
2nd year PGT
IPGMER & SSKM Hospital

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Derma Times
News, Trends & Developments

*On **March 18, 2026**, the FDA approved **(icotrokinra)**, a first-in-class, once-daily oral interleukin-23 (IL-23) receptor antagonist for treating moderate-to-severe plaque psoriasis.*

It is approved for adults and adolescents (aged 12+, ≥ 40 kg) who are candidates for systemic therapy or phototherapy.

Key Details Regarding Icotrokinra Approval:

- ***Clinical Efficacy**: In Phase 3 ICONIC studies, around 70% of patients achieved clear or almost clear skin (IGA 0/1) at week 16, with significant improvements in scalp and genital areas. It demonstrated superiority over both placebo and deucravacitinib.*
- ***Administration**: Icotrokinra is a 200mg tablet taken orally once daily on an empty stomach, requiring patients to wait at least 30 minutes before eating.*
- ***Safety Profile**: Common adverse reactions (≥ 1%) include headache, nausea, cough, fungal infections, and fatigue.*

Pill not actual size

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Quiz Zone

1) *X is a first in its class, orally active, macrocyclic peptide that specifically targets IL-23 receptor. Its effectiveness in the hallmark 'ICONIC' trial has led the FDA to approve its use as a novel agent for treating moderate to severe psoriasis. Identify X.*

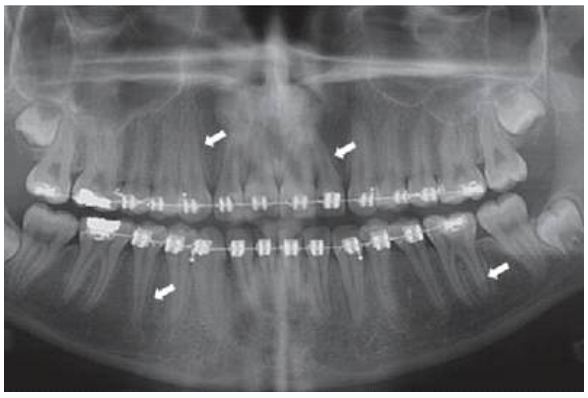
2) *Study the image provided [fig 1] and identify the famous physician.*

3) *Mrs X presented to her dentist for a toothache. The dentist ordered an oral pantomogram. She reported to her dentist that she was under treatment for a specific rheumatological disorder which made it difficult for her to open her mouth wide. What is the finding which is observed in the OPG [fig 2] and also the associated disease.*

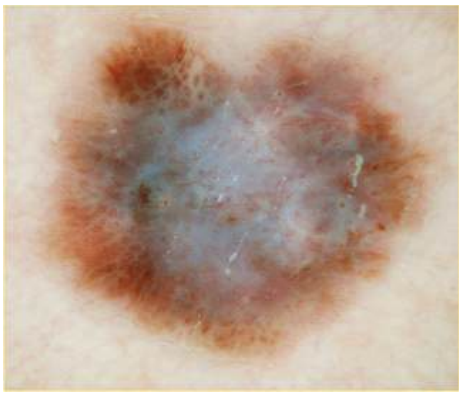
4) *Mr G presented with the chief complaint of a long standing mole on his chin which had recently started to show some changes since the last 3 months. Dermoscopy by his dermatologist revealed the following sign [fig 3]. Identify the sign seen at the centre of the lesion.*

[fig 1]

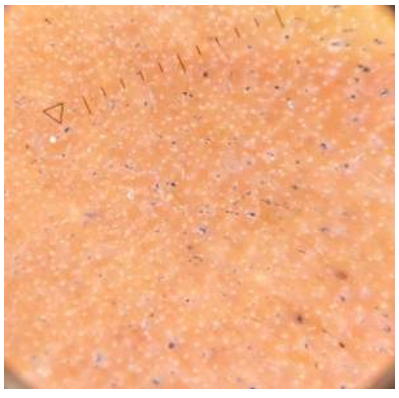
5) *A 4 year old boy was brought to the OPD by his anxious mother who was worried about the gradual progressive loss of hair of her child. On examination, apart from the sparse hair on his scalp and eyebows, multiple, spiny, folliculocentric papules were observed over his scalp , eyebrows and proximal arms. Dermoscopy revealed this characteristic sign [fig 4]. Identify the sign and the gene associated with disease being referred to.*



[fig 2]



[fig 3]



[fig 4]

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.

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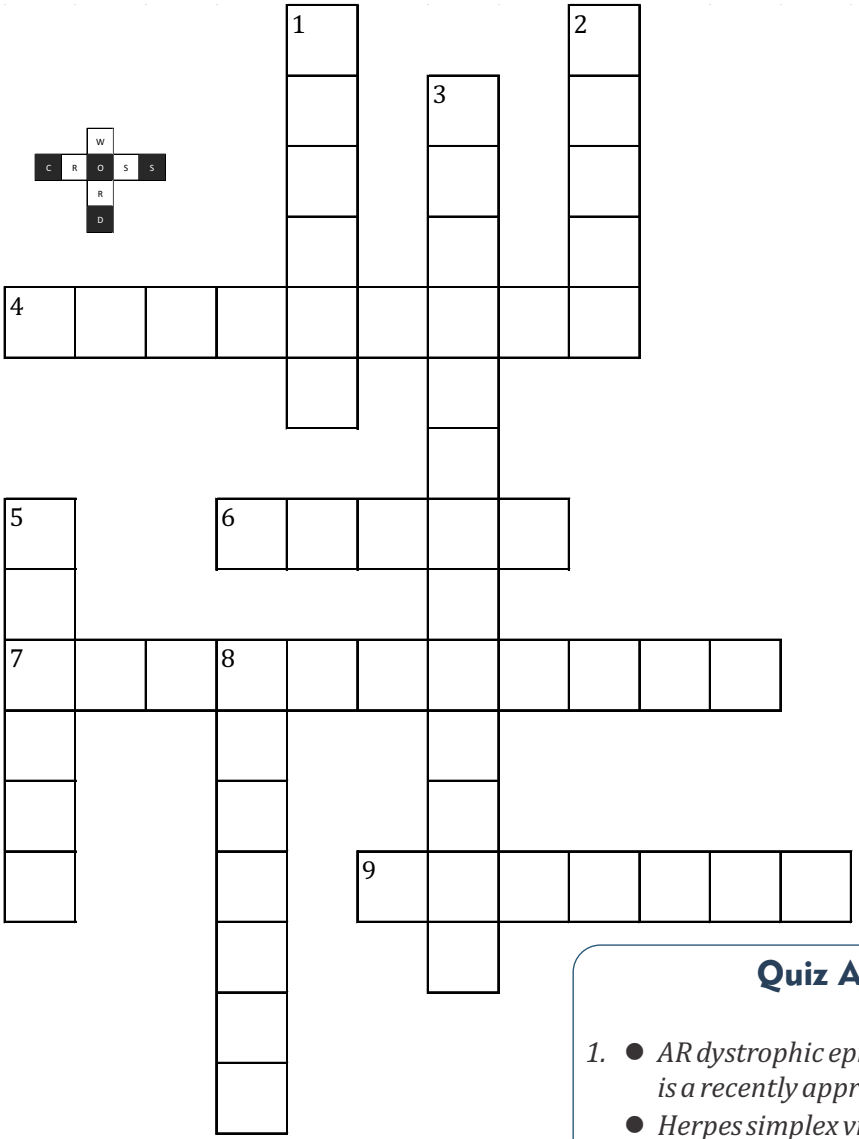
Brainstorm

Across

4. Named area spared in photoallergic contact dermatitis.
6. Stain used to differentiate collagen, elastin, mucin, fibrin & muscle in a single section.
7. This small molecule is FDA approved to treat both psoriasis & seborrheic dermatitis.
9. Mosaic based IIF assay to detect multiple autoantibodies in immunobullous disorders.

Down

1. Triad of panniculitis, pancreatitis & arthritis.
2. The solution used to carry out tumescent liposuction.
3. Marquee sign is seen in this disease.
5. Auspitz sign can be positive in this condition.
8. ASWAMEDHAM Campaign is related to this disease.



Quiz Answer Volume-3, Issue-12

1. ● *AR dystrophic epidermolysis bullosa (**Beremagene geperpavec** is a recently approved gene therapy)*
   ● *Herpes simplex virus type 1.*
2. ● *EGAWA TEST.*
   ● *POWER OF DORSAL INTEROSSEI SUPPLIED BY ULNAR NERVE.*
3. ● *Bloom's syndrome.*
   ● *Highly elevated spontaneous sister chromatid exchange rate.*
4. *Colloid milium*
5. *WHIM Syndrome.*

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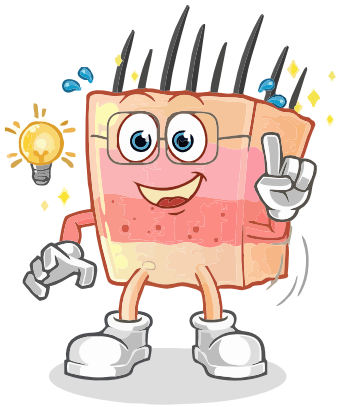
Dermwiz

I don't
grow evenly, I
choose my side,
In patches and parts, I distort
the guide.
A silent error after life began,
Leaves patterns no one fully can plan.

One limb may lengthen, another stay small,
Skin and bone answer a different call.
No family link, I appear alone—
A mosaic written deep in tone.

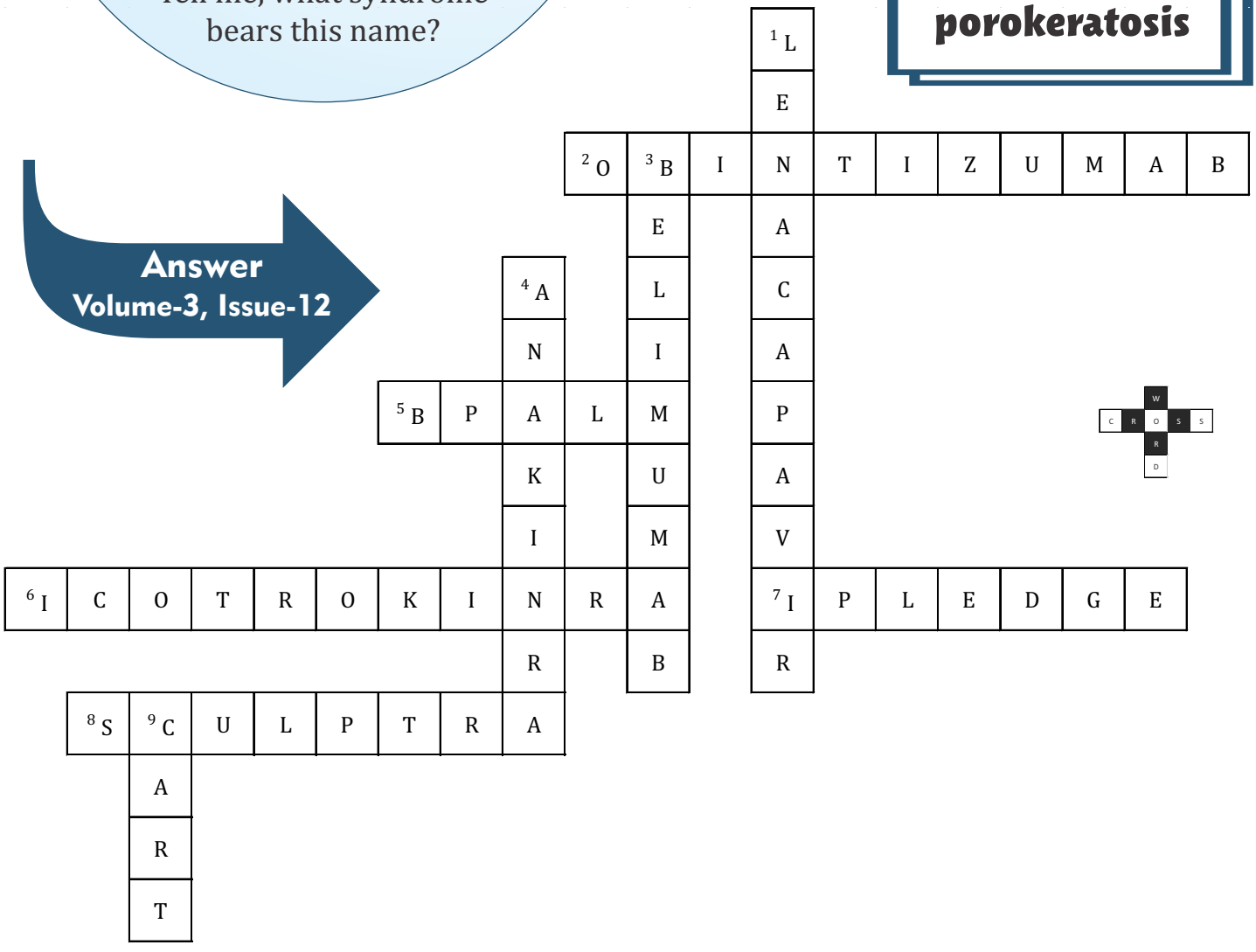
From quiet start to striking frame,
Tell me, what syndrome
bears this name?



Dermwiz Answer
Volume-3, Issue-12

porokeratosis

Answer
Volume-3, Issue-12



Save the Date

INDIAN ASSOCIATION OF DERMATOLOGISTS VENEREOLOGISTS & LEPROLOGISTS
IADVL
1973
WEST BENGAL STATE BRANCH

14th Mid Term Conference

Experience and dynamicity shapes the future of Dermatology

27th & 28th June 2026

Venue

Anticlock Suites & Resorts, Dhaldangamore
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

Scan to Register

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*

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Save the Date

ermazone east
uticon wb
2026

32nd Zonal Conference of IADVL & 29th Annual State Conference of IADVL WB

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