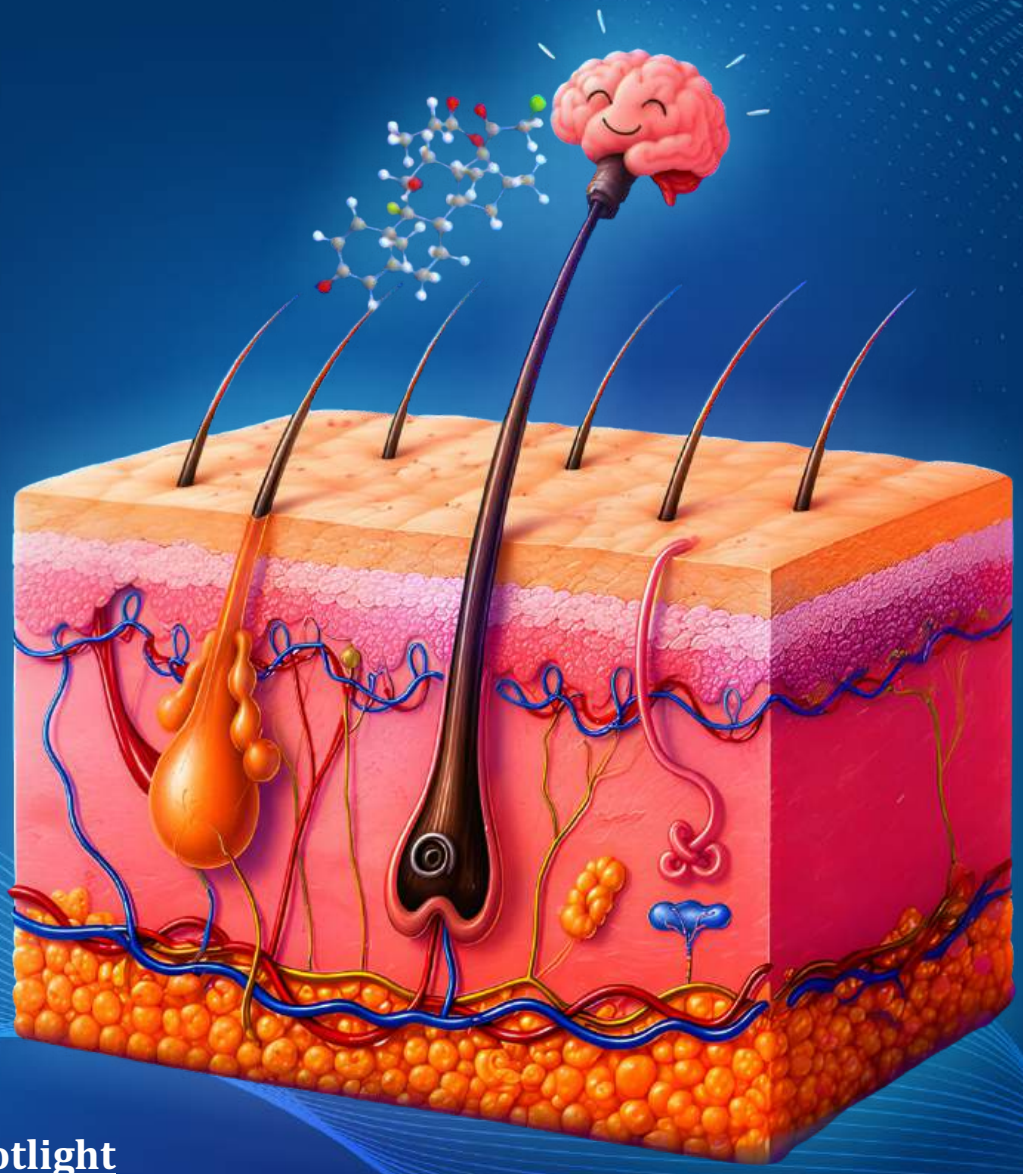
Indian Association of Dermatologists, Venereologists & Leprologists West Bengal State Branch

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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Note from the President

Dear Colleagues,

Warm Greetings from IADVL WB.

I sincerely thank all our members for their active participation in our various scientific and outreach programs.

I would like to encourage our young colleagues and residents to actively participate in the academic programs and also focus on research activities and publish their work.

We recently had SIG Pediatric Dermatology at Kolkata which was a resounding success both academically and participation wise. I would sincerely like to thank Dr Anupam Das and our dynamic Hony Secretary Dr Somenath Sarkar for arranging the program immaculately, and all the national and State faculties and the delegates for their erudite and active participation.

We have a number of academic events lined up in the near future in the form of clinical meetings, webinars, SIGs and Guru Bani. There are a number of community outreach programs in the pipeline. I would urge each and every member to participate in the above actively.

I would like to congratulate the Editor of Skintellect Dr Ameli Sarkar and her Team of young and active members for their untiring efforts in publishing excellent issues of Skintellect well in time and would also like to thank the authors for their highly academic contributions.

Together we can make our association stronger for the benefit of each other.

I wish each member and their families good health and happiness.

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 the July 2026 issue of Skintellect, the official newsletter of the IADVL West Bengal State Branch.

The past few months have been marked by vibrant academic engagement and enthusiastic participation from our members, reflecting our collective commitment to advancing dermatology through continuous learning and collaboration. Our State Branch continues to uphold its tradition of fostering academic excellence while strengthening professional bonds across the dermatology fraternity.

I am delighted to note the remarkable success of our Special Interest Group (SIG) programs, which have provided focused, high-quality academic discussions on diverse subspecialties in dermatology. These sessions have served as excellent platforms for knowledge exchange, interactive learning, and sharing of practical clinical experiences.

Our SIG Pediatric Dermatology program deserves special mention for its insightful deliberations on the unique challenges encountered in pediatric dermatology. The enthusiastic participation of faculty and delegates has enriched these sessions and reinforced the importance of subspecialty-focused education.

The Guru Bani series has continued to inspire us by bringing together our respected senior teachers and mentors, whose vast clinical experience and timeless wisdom remain invaluable to both young and experienced dermatologists alike. These interactions not only enhance our academic knowledge but also strengthen the tradition of mentorship that defines our specialty.

Equally commendable are our Derma Abahan programs, which have successfully combined academic enrichment with service to society. Through these initiatives, our members have demonstrated that dermatology extends beyond clinics and conference halls, reaching communities through awareness, education, and compassionate patient care. Such endeavors exemplify the social responsibility that our association proudly embraces.

As we move forward, I encourage every member to actively participate in the academic, educational, and community outreach initiatives of our State Branch. Your enthusiasm, ideas, and unwavering support are the driving force behind the continued growth and success of IADVL West Bengal.

I congratulate the Editorial Team of Skintellect for their dedicated efforts in bringing out another informative and engaging issue. I am confident that this edition will provide valuable insights and stimulate further academic curiosity among our readers.

Let us continue to learn, collaborate, innovate, and serve with dedication, keeping alive the spirit of excellence that defines the IADVL West Bengal State Branch.

With warm regards,

Dr. Somenath Sarkar
Honorary Secretary
IADVL WB

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Editors Desk

Dear Readers,

July has been a month of remarkable academic engagement and collaborative learning for IADVL West Bengal, reaffirming our collective commitment to excellence in dermatology and continuous professional development.

The month witnessed two successful Continuing Medical Education (CME) programmes, held in Durgapur and Purulia, respectively. These academic gatherings brought together dermatologists from across the districts and provided an excellent platform for knowledge exchange through stimulating lectures, interactive discussions, and invaluable insights from distinguished faculty members.

One of the defining highlights of the month was the SIG Pediatric Dermatology Conference, held at Taj Bengal, which attracted an impressive attendance of 104 delegates. The conference offered an enriching academic experience, with comprehensive deliberations on contemporary concepts, challenging clinical scenarios, and recent advances in pediatric dermatology, making it a memorable learning event for all participants.

Our monthly Clinical Meet, hosted at IPGME&R and SSKM Hospital, once again underscored the importance of collaborative learning through engaging case discussions and thought-provoking academic interactions.

This edition of Skintellect brings together an exciting collection of features. In 'Dermatologist on Spotlight', we are privileged to feature Dr. Sachin Verma, a renowned and versatile dermatologist whose clinical acumen, innovations in aesthetics, and entrepreneurial vision continue to inspire the dermatology fraternity.

The 'Case Podium' presents an intriguing clinical case contributed by Dr. Kakali Mridha (HOD) , from SSKM Hospital, encouraging readers to sharpen their diagnostic approach through real-world clinical experience.

In 'DermBuzz', Dr. Subhasmita Baisya eloquently explores the fascinating relationship between cutaneous manifestations and CD4 counts, illustrating how the skin often serves as a mirror of the immune system. Complementing this, our resident contributor, Dr. Sneha Saha, presents a well-curated review on the expanding role of anti-androgens in dermatology, highlighting their growing therapeutic relevance across a spectrum of dermatological disorders.

Adding a refreshing artistic dimension to this issue, 'Dermaginations' features a beautiful poem by Dr. Aniruddha Ghosh, reminding us that the practice of medicine is enriched not only by science but also by creativity and human expression.

As always, we conclude with our ever-popular Quiz Zone and Crossword and dermwiz ,thoughtfully designed to make learning enjoyable while reinforcing key dermatological concepts.

We hope this edition informs, inspires, and stimulates thoughtful discussion. Thank you for your continued encouragement and support as we strive to make Skintellect a vibrant platform for academic excellence, shared experiences, and creative expression.

Happy reading!

Dr. Ameli Sarkar
Editor, Skintellect,
The IADVL WB Monthly Newsletter

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DERMATOLOGIST SPOTLIGHT: DR. SACHIN VARMA

1. ***Your journey in dermatology has been both inspiring and multifaceted. What motivated you to pursue dermatology, and what milestones have most significantly shaped your career?***

Interestingly, dermatology was not my first choice. During my postgraduate counselling at MAHE, my initial aspiration was to pursue Paediatrics. However, based on my rank, my realistic options were the surgical specialties or Dermatology. After carefully considering the scope of the specialty and the opportunities it offered, I chose Dermatology—and, in retrospect, it turned out to be one of the best decisions of my career.

What made the timing particularly exciting was that dermatology itself was undergoing a transformation. Thirty years ago, the specialty was very different from what it is today. Aesthetic dermatology was still in its infancy, dermatosurgery was only beginning to gain recognition, and many of the technologies that are now considered routine were just being introduced into clinical practice.

Joining Kasturba Medical College, Manipal, in 1996 as a post graduate student for doing my MD was therefore a defining milestone in my career. At that time, KMC had one of the most advanced dermatology departments in the country, equipped with facilities such as phototherapy, CO_2 laser, and a well-established dermatosurgery unit, where procedures like vitiligo surgery were already being performed. Being trained in such an environment exposed me early to cutting-edge dermatology and fostered my interest in procedural dermatology, innovation, and technology-driven patient care.

The next defining phase of my career came when I joined Kasturba Medical College, Manipal, as an Assistant Professor and was posted to the Sikkim Manipal Institute of Medical Sciences to help establish and develop the Department of Dermatology. Building a department from the ground up was an invaluable learning experience. Working in a relatively independent setting meant managing a wide spectrum of dermatological disorders, often with limited resources and without the immediate support of senior colleagues. It gave me the confidence to evaluate and manage complex cases independently, strengthened my clinical decision-making, and taught me the importance of self-learning, resourcefulness, and responsibility. Looking back, those years were instrumental in shaping me as a clinician.

That experience proved invaluable when Apollo Gleneagles Hospital was established in Kolkata and I was appointed as Consultant and Head of the Department of Dermatology at what was, for me, a relatively young stage in my career. It was both a tremendous honour and a significant challenge. Building a new department in a leading corporate hospital involved much more than clinical practice—it meant developing services, introducing advanced procedures, creating clinical protocols, and earning the confidence of patients and colleagues alike. Managing tertiary referral cases, treating high-profile and VIP patients, and meeting the expectations of a rapidly growing institution demanded constant learning and unwavering commitment. Regularly attending conferences, keeping abreast of the latest literature, learning from peers across specialties, and, above all, the blessings of God and the support of my colleagues enabled me to overcome those challenges and establish a strong and trusted department.

The natural progression of that journey was the establishment of Skinvita Clinic. For me, Skinvita was never just about starting another practice; it was about creating a centre of excellence where clinical dermatology, dermatosurgery, aesthetics, lasers, regenerative medicine, and technology could come together under one roof. It provided the freedom to pursue innovation, invest in cutting-edge technology, and deliver personalized, evidence-based care while remaining firmly rooted in evidence based medical practice. Even today, my greatest satisfaction comes from continuously learning, embracing new advances, and seeing the positive impact that dermatology can have on the lives and confidence of patients.

2. ***Aesthetic dermatology is evolving at an unprecedented pace. In your opinion, what are the most exciting advancements in the field, and how do you foresee the future of aesthetics over the next decade?***

The field is moving beyond simply treating wrinkles or pigmentation. The future is about regenerative medicine, personalized treatment protocols, and preserving skin health rather than merely correcting ageing.

Advances such as exosomes, polynucleotides, hybrid hyaluronic acid technologies, collagen biostimulators, lasers and energy-based devices are redefining facial rejuvenation. At the same time artificial intelligence is coming in a big way which will help us objectively analyze skin, plan treatments, and monitor outcomes.

Over the next decade, I believe aesthetic dermatology will become increasingly personalized. Genetic profiling, biomarker-based treatments, and AI-assisted treatment planning will enable us to design individualized anti-ageing protocols. Patients are also moving away from dramatic transformations and towards subtle, natural-looking enhancements that help them age gracefully, and I believe this philosophy will continue to shape the future of aesthetics.

3. ***Biologics have transformed the management of several chronic inflammatory dermatoses. How has your experience with biologic therapy influenced your clinical practice, and what developments are you most optimistic about?***

The introduction of biologics has truly revolutionized the management of chronic inflammatory skin diseases. Conditions such as psoriasis, which once required long-term conventional immunosuppressants with variable efficacy and significant monitoring, can now be managed with highly targeted therapies that offer sustained disease control and dramatically improve patients' quality of life.

What excites me most is the precision with which these therapies target specific immune pathways. The availability of newer IL-23 and IL-17 inhibitors has transformed psoriasis management, while biologics targeting the Th2 inflammatory pathway, particularly IL-4 and IL-13, have dramatically improved outcomes for patients with moderate-to-severe atopic dermatitis. In parallel, the emergence of Janus kinase (JAK) inhibitors has opened a new era in dermatology. Their rapid onset of action and efficacy in conditions such as atopic dermatitis, alopecia areata, vitiligo, and several other inflammatory dermatoses have significantly expanded our therapeutic armamentarium.

Looking ahead, I am particularly optimistic about the future of precision medicine. Advances in biomarkers, pharmacogenomics, and immune profiling may soon allow us to predict which biologic or targeted therapy is most likely to benefit an individual patient, enabling truly personalized treatment. I also foresee biologics and small-molecule targeted therapies expanding into newer indications, offering safer and more effective options for diseases that were once difficult to manage. It is an exciting time to be a dermatologist

4. ***As a dermatologist with a keen interest in dermatosurgery, what innovations or techniques do you believe have had the greatest impact on patient outcomes and procedural safety?***

Procedural dermatology has undergone remarkable evolution over the past decade

The integration of peels, electrosurgery, radiofrequency, lasers, energy based devices fillers botox and now regenerative approaches such as platelet-rich plasma and exosome-based therapies has expanded the scope of dermatosurgery.

Perhaps the greatest advancement, however, is not a single technology but increased awareness in patients and phones with camera which is making them more conscious of their looks than ever before. Also increased safety and success of Dermatosurgery procedures greater learning opportunities in various conferences are making the Dermatosurgery more popular and improving cosmetic outcomes and minimizing complications

5. ***Beyond clinical excellence, you have demonstrated a strong entrepreneurial spirit. What inspired you to venture into entrepreneurship, and what lessons would you share with young dermatologists aspiring to build successful practices or healthcare ventures?***

   Building a practice taught me that medicine and entrepreneurship are not opposing concepts. A well-managed practice allows us to deliver better patient experiences, invest in advanced technologies, and create opportunities for innovation.

   My advice to young dermatologists is to first become excellent clinicians. Clinical credibility is the strongest foundation for any successful practice. Invest in lifelong learning, communicate honestly with patients, embrace technology thoughtfully, and remember that reputation is built through trust, not marketing. Success is ultimately a by-product of consistently delivering value.

6. ***The integration of technology, artificial intelligence, and digital platforms is reshaping dermatology. Which emerging technologies do you believe will have the greatest impact on clinical practice and patient care?***

   Artificial intelligence will undoubtedly transform dermatology, particularly in skin imaging, lesion analyis and diagnostic support. I think clinical judgment by the doctor will still win over AI but AI can enhance decision-making and improve efficiency.

   Beyond AI, digital dermoscopy, will improve substantially making us look into skin reducing scope of biopsies

   Also digital learning will become a norm and so is learning through AI, books will slowly become obsolete

7. ***As someone deeply involved in multiple facets of dermatology, how do you maintain a balance between patient care, academics, innovation, and entrepreneurship without compromising quality?***

   I don't see patient care, academics, nnovation, and entrepreneurship as competing priorities—they complement one another. Patient care remains at the heart of everything while academics ensure that practice stays evidence-based. New learning, Innovation and entrepreneurship simply provide the platform to deliver. I make it a point to stay updated through conferences, scientific literature, and continuous learning, I am blessed to have a good team of talented dermatologists who help maintain quality.

8. ***You have travelled extensively across the world. How have your international experiences influenced your perspective on dermatology, aesthetics, and healthcare delivery in India?***

   Travelling has been one of the greatest learning experiences of my career. Every national or international conference exposes to new ideas, innovative procedures, newer technologies and different ways of approaching patient.

   Beyond the scientific sessions, I often spend a great deal of time exploring the exhibition stalls, where many breakthrough technologies and products are showcased. These interactions often sparked ideas that I thoughtfully adapted to my practice.

   At every conference, one may come back with only three or four truly valuable ideas, which may seem modest considering the time and effort involved. But over the years, these small learnings accumulate, build upon one another, and eventually create an exponential impact on one's clinical practice and way of thinking.

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DERMBUZZ :
FROM RASH TO REALITY: DECODING CD4 THROUGH THE SKIN

Dr. Subhasmita Baisya
Assistant Professor
Arambag

The skin is not merely a barrier — it is a dynamic immunological organ teeming with lymphocytes, dendritic cells, and cytokine networks. Among these, CD4+ T cells occupy a central role in orchestrating cutaneous immune responses.

The skin harbours one of the largest reservoirs of immune cells in the body. CD4+ T cells are present in both the epidermis and dermis, with distinct phenotypes in each compartment. In epidermis CD4+ T cells here are predominantly memory phenotype (CD45RO+), enriched for tissue-resident memory T cells (TRM) that respond rapidly to previously encountered antigens. The dermis contains a more diverse population including circulating effector memory cells, regulatory T cells, and Th17 cells involved in barrier defence.

***Clinical Pearl**: Skin-homing CD4+ T cells express cutaneous lymphocyte-associated antigen (CLA) and CCR10, enabling them to traffic to inflamed skin via E-selectin and CCL27 interactions.*

Th1-Mediated Dermatoses

Th1 cells produce IFN-γ, TNF-α, and IL-2, driving cell-mediated immunity against intracellular pathogens. In the skin, chronic Th1 activation underlies several classic inflammatory dermatoses.

***Psoriasis**: While Th17 dominates early plaque psoriasis, Th1 cells (IFN-γ+) are abundant in chronic lesions. They synergise with Th17 cells to sustain keratinocyte hyperproliferation and neutrophil recruitment.*

***Lichen Planus**: A Th1-driven interface dermatitis where CD8+ cytotoxic T cells are activated by Th1cytokines. IFN-γ upregulates MHC Class I on keratinocytes, making them targets for immune attack.*

***Cutaneous Sarcoidosis**: Non-caseating granulomas driven by Th1 cytokines. TNF-α is central to granuloma formation, explaining the efficacy of TNF inhibitors in refractory cases.*

Th2 Pathways and Atopic Dermatitis

Th2 cells secrete IL-4, IL-5, IL-13, and IL-31 — cytokines that drive IgE class switching, eosinophil recruitment, mast cell activation, and pruritus. In atopic dermatitis (AD), this cascade is amplified by epithelial barrier defects (filaggrin mutations) and dysbiosis (S. aureus colonisation). IL-4/IL-13 suppress Th1 and Th17, perpetuating atopy. Biologic targets like Dupilumab (IL-4Rα), Tralokinumab (IL-13) block Th2 signalling.

Th17 Axis: Psoriasis and Beyond

The Th17 pathway has revolutionised our understanding of psoriasis and related disorders. IL-23 from dendritic cells drives Th17 differentiation; Th17 cells produce IL-17A, IL-17F, and IL-22, which act on keratinocytes to induce antimicrobial peptides, chemokines, and proliferative signals. Key Diseases includePlaque psoriasis, pustular psoriasis, psoriatic arthritis, hidradenitis suppurativa, and some forms of cutaneous lupus

***Targeted Therapies** include Secukinumab (IL-17A), Ixekizumab (IL-17A), Guselkumab (IL-23p19), Risankizumab (IL-23p19), Tildrakizumab (IL-23p19)*

***Paradoxical Effects**: IL-17 blockade can unmask or worsen IBD and candidiasis — reflecting Th17's role in mucosal barrier immunity.*

Regulatory T Cells: Guardians of Cutaneous Tolerance

CD4+CD25+FOXP3+ regulatory T cells (Tregs) are essential for maintaining immune tolerance in the skin. ***Diseases of Treg Dysfunction:***

***IPEX Syndrome**: FOXP3 mutation with severe eczema, enteropathy, autoimmunity*

***Alopecia Areata**: Reduced Treg suppression of CD8+ attack on hair follicles*

***Vitiligo**: Impaired Treg control of melanocyte-specific CD8+ cells*

***SLE Cutaneous**: Treg dysfunction permits autoantibody-mediated skin injury*

CD4 in Infectious Dermatology

CD4+ T cells are indispensable for controlling cutaneous infections. Their depletion or dysfunction — whether from HIV, immunosuppressive therapy, or genetic immunodeficiency — dramatically alters the skin's infectious landscape.

HIV and skin:

Manifestations evolve predictably with progressive immunosuppression though ART modifies patterns.

CD4 >500 cells/µL (Early/Moderate Immunosuppression)

- *Seborrheic Dermatitis:*
- *Pruritic Papular Eruption (PPE)*
- *Xerosis and Acquired Ichthyosis: Dry, scaly skin; contributes to pruritus.*
- *Psoriasis: New-onset or exacerbated; more severe and relapsing.*
- *Superficial Fungal Infections: Tinea corporis/cruris, pityriasis versicolor (still common at preserved counts).*
- *Drug Reactions: Fixed drug eruptions, lichenoid eruptions.*

CD4 200–500 cells/µL (Progressive Immunosuppression)

- *Worsening of above conditions.*
- ***Eosinophilic Folliculitis (HIV-EF)**: Sterile, pruritic follicular papules/pustules on face, trunk, upper arms. Distinct from classic Ofuji disease; highly characteristic of HIV.*
- ***Herpes Zoster**: Multidermatomal or recurrent.*
- ***Molluscum Contagiosum**: Numerous, giant, or facial lesions.*
- ***Oral Hairy Leukoplakia** (EBV-related; mucosal marker).*
- ***Kaposi's Sarcoma** (early patches/plaques): Purple-red macules on skin/mucosa; HHV-8 associated.*

CD4 <200 cells/µL (Advanced/AIDS)

- ***Opportunistic Infections:***
- *Candidiasis (oral, esophageal, intertriginous).*
- *Disseminated herpes simplex/varicella.*
- *Deep fungal: Cryptococcosis (umbilicated papules mimicking molluscum), histoplasmosis, penicilliosis.*
- *Bacillary angiomatosis (vascular papules/nodules; Bartonella).*
- *Atypical mycobacterial infections.*
- ***Severe/Extensive Kaposi's Sarcoma.***
- ***Refractory Seborrheic Dermatitis and EF.***
- ***Prurigo Nodularis** and chronic pruritus.*

Additional HIV-Specific or Immune Dysregulation Phenomena

- ***Papular Pruritic Eruption (PPE)****: Persists or intensifies with lower CD4.*
- ***Drug Hypersensitivity Syndromes****: e.g., DRESS (Drug Reaction with Eosinophilia and Systemic Symptoms); higher incidence; altered dermal CD4/CD8 ratios.*
- ***Immune Reconstitution Inflammatory Syndrome (IRIS)****: Paradoxical worsening of infections/dermatoses upon ART initiation as CD4 rises.*
- ***Neoplasms****: Increased squamous/basal cell carcinomas; cutaneous lymphomas (including cytotoxic CD4+ infiltrates in older patients).*
- ***Vascular and Pigmentary Changes****: Longitudinal melanonychia, telogen effluvium.*

Histopathology Highlights:

- *PPE/EF: Perivascular lymphocytic infiltrates with eosinophils.*
- *KS: Spindle cells, vascular slits, HHV-8 positivity.*
- *Reduced epidermal CD4+ cells in advanced disease; increased CD8+ infiltrates.*

Lepromatous Leprosy

A classic example of Th2-skewed immunity failing to control M. leprae. The anergic state (low CD4 response) permits massive bacillary load, contrasting with tuberculoid leprosy where robust Th1 responses limit disease.

Clinical Takeaways: From Bench to Bedside

A firm grasp of CD4 biology transforms how we approach diagnosis and treatment in dermatology. The following principles synthesise the key learning points from this module.

Phenotype the Inflammation

Before selecting a biologic, identify the dominant CD4 subset: Th1 (psoriasis, LP), Th2 (AD, prurigo), Th17 (psoriasis, HS), or mixed. Histopathology with immunohistochemistry can aid in ambiguous cases.

Understand the Cytokine Network

Cytokines do not act in isolation. Blocking IL-17 may shift balance toward Th1 or Th2. Anticipate paradoxical reactions and monitor for unmasking of other inflammatory pathways.

Consider Treg Status

In autoimmune blistering diseases, vitiligo, and alopecia areata, therapies that enhance Treg function (low-dose IL-2, JAK inhibitors) are emerging as rational approaches.

CD4 Count Guides Infection Risk

In HIV-positive patients or those on systemic immunosuppression, correlate CD4 counts with cutaneous infection risk. Opportunistic infections are a direct reflection of CD4-mediated immunity. Mucocutaneous lesions correlate with CD4 decline and can predict opportunistic infection risk.

- *Early dermatologic recognition facilitates timely HIV diagnosis and linkage to care.*
- *In the ART era, focus shifts to chronic inflammatory conditions, aging skin, and equity in dermatology access.*

"The skin is the mirror of the immune system — every rash tells a story of T cell biology."

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RESIDENT'S CORNER: ANTI-ANDROGEN IN DERMATOLOGY

Dr. Sneha Saha
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Anti-androgens have long been an integral part of therapeutic practice across various medical specialties. In dermatology, growing recognition of the role of androgen signalling in the pathogenesis of disorders such as acne, female pattern hair loss, androgenetic alopecia, seborrhoea, hirsutism, and hidradenitis suppurativa has led to their increasing clinical application. By targeting the underlying hormonal component of these conditions, anti-androgens offer a rational, mechanism-based therapeutic approach, particularly in patients with evidence of androgen excess or hormone-driven disease.

Androgen-mediated effects targeted by anti-androgen therapy in dermatology

Androgens exert diverse effects on the skin and its appendages. Anti- androgen therapy aims to counter the following pathogenic mechanisms:

- *Increased sebaceous gland activity and sebum production : acne vulgaris, hidradenitis suppurativa*
- *Progressive miniaturization of scalp hair follicles: androgenetic alopecia*
- *Conversion of vellus hair into terminal hair in androgen-sensitive areas : hirsutism*

Classification of anti-androgens based on mechanism of action

1. ***Androgen receptor antagonists***
   - *Spironolactone*
   - *Cyproterone acetate*
   - *Flutamide*
   - *Bicalutamide*
   - *Clascoterone (topical)*
2. ***Androgen synthesis inhibitors***
   - *Ketoconazole*
   - *Abiraterone acetate*
   - *Corticosteroids (e.g., dexamethasone, prednisolone) in selected disorders such as congenital adrenal hyperplasia*
3. ***5α-Reductase inhibitors*** *(Inhibit the conversion of testosterone to dihydrotestosterone [DHT])*
   - *Finasteride*
   - *Dutasteride*
4. ***Antigonadotropins*** *(Suppress gonadal androgen production by inhibiting LH and FSH secretion)*
   - ***GnRH agonists****: Leuprolide, Goserelin, Triptorelin*
   - ***GnRH antagonists****: Degarelix, Relugolix*
5. ***Combined oral contraceptive pills (COCs)*** *(Suppress ovarian androgen production, increase sex hormone-binding globulin, and reduce free testosterone)*
   - *Ethinyl estradiol + Cyproterone acetate*
   - *Ethinyl estradiol + Drospirenone*
   - *Ethinyl estradiol + Desogestrel*
   - *Ethinyl estradiol + Norgestimate*

6. *Indirect anti-androgenic agents (insulin sensitizers)*

- *Metformin*
- *Myo-inositol*

These agents improve hyperinsulinemia, thereby reducing ovarian androgen production, particularly in women with polycystic ovary syndrome.

Oral Dose of few anti androgenic drugs:

Drugs	Acne vulgaris	Androgenetic alopecia	Hirsutism	Hidradenitis Suppurativa
Spironolactone (initial dosing)	Initial : 25-50mg/day Maintenance : 50-100mg/day Maximum : 200mg/day	• FPHL : 25-50mg/day day 4-day 22 of menstrual cycle • MPHL : X	50mg twice daily	50-200mg/day
Cyproterone acetate (CA)	• mild to moderate cases: 2mg CA + ethinylestradiol 35mcg OD for 21days • Moderate to severe cases : 25-50mg/day for day 1- day 10 of • menstrual cycle (combined with estrogen containing OCP)	• FPHL : 25-50mg/day for day 1- day 10 of menstrual cycle (combined with estrogen containing OCP) • MPHL : X	• 50-100mg/day for day 1- day 10 of menstrual cycle (combined with estrogen containing OCP)	50-100mg/day
Flutamide	125-250mg/day	125-250mg/day	250mg/day (max effectivity shown at 500mg but avoided due to hepatotoxicity)	X
Finasteride	X	Female: 1-5mg/day (generally 2.5-5mg/day) Male : 1mg/day	2.5-5mg/day	X
Dutasteride	X	0.5mg/day	0.5mg/day (not first line)	X
Bicalutamide	10-25mg/day	10-25mg/day	25-50mg/day	Few reports show 25-50mg/day

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Topical antiandrogens dosage:

Topical anti-androgen	Dose	Indication
Clascoterone 1% cream	Twice daily	Acne vulgaris
Spironolactone cream	Twice daily	Acne vulgaris
Finasteride 0.25% solution/ spray	Once daily	Androgenetic alopecia
Dutasteride	Once daily	Androgenetic alopecia
Ketoconazole lotion	Twice daily	Adjunct in androgenetic alopecia

Side effects :

Pregnancy should be avoided during treatment with systemic anti-androgen therapy because several agents may feminize a male fetus or have potential fetal toxicity.DrugsEffective contraception is recommended for women of child-bearing potential.

Drugs	Side effects	Monitoring
Spironolactone	Gynaecomastia, Menstrual irregularities, breast tenderness, fatigue, dizziness, Hyperkalemia, teratogenicity	Baseline K, creatinine. To be repeated after 1month of treatment.
Cyproterone acetate	Weight gain, menstrual irregularities, decreased libido, mood changes, Hepatotoxicity, meningioma, DVT, teratogenicity	LFT
Flutamide	Dry skin,GI upset, decreased libido, fatal Hepatotoxicity, teratogenicity	Baseline LFT. Then Monthly LFT for first 4 months then every 3 months.
Finasteride	Decreased libido, erectile dysfunction, reduced ejaculate volume, teratogenicity	
Dutasteride	Decreased libido, erectile dysfunction, ejaculatory disorders, teratogenicity	

New drugs

Several novel anti-androgen therapies are being developed with the aim of improving efficacy while minimizing systemic adverse effects. These include:

- ***Pyrilutamide (KX-826)**: A novel topical androgen receptor antagonist currently in late-stage clinical trials for androgenetic alopecia and being explored for other androgen-mediated dermatoses.*
- ***GT20029**: A first-in-class topical androgen receptor degrader (PROTAC technology) that promotes degradation of the androgen receptor rather than simply blocking it; currently in clinical development for androgenetic alopecia and acne vulgaris.*
- ***Breezula (Clascoterone 7.5% solution)**: A higher-strength topical formulation of clascoterone under investigation for androgenetic alopecia.*
- ***Topical finasteride**: Newer topical formulations are increasingly being evaluated and adopted for androgenetic alopecia to reduce systemic exposure while maintaining clinical efficacy.*

These emerging therapies represent the next generation of anti-androgen treatment, with a focus on targeted delivery, improved safety profiles, and enhanced patient adherence. Continued clinical trials will define their role in routine dermatological practice.

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CASE-PODIUM:
ATRICHIA WITH PAPULAR LESIONS

Dr. Kakali Mridha
Prof. & Head, Dept. of DVL
IPGMER & SSKM Hospital, Kolkata

Atrichia with papular lesions (APL) is a rare autosomal recessive disorder resulting from mutations in the hairless (hr) gene on chromosome 8, manifesting as generalised, permanent loss of hair associated with the clinically distinctive occurrence of spiny follicular papules over hair-bearing skin. It typically presents in early adolescence or adulthood with complete hair loss; this case highlights a rare presentation of the disease in early childhood, with hair loss still incomplete at the time of diagnosis.

A 2 year 2 month old female child was brought by her parents with the chief complaint of loss of scalp and eyebrow hair, unresponsive to treatment by multiple physicians. Born with normal-appearing hair, she began losing hair at 2 months of age, with almost all scalp and eyebrow hair shed within a few months. Concurrently, she developed papular lesions over the scalp, forehead and proximal upper limbs. She had been treated elsewhere as a case of alopecia universalis, without response. There was no developmental delay or growth retardation, and no family history of similar hair loss, though the parents were consanguineous.

Figure 1

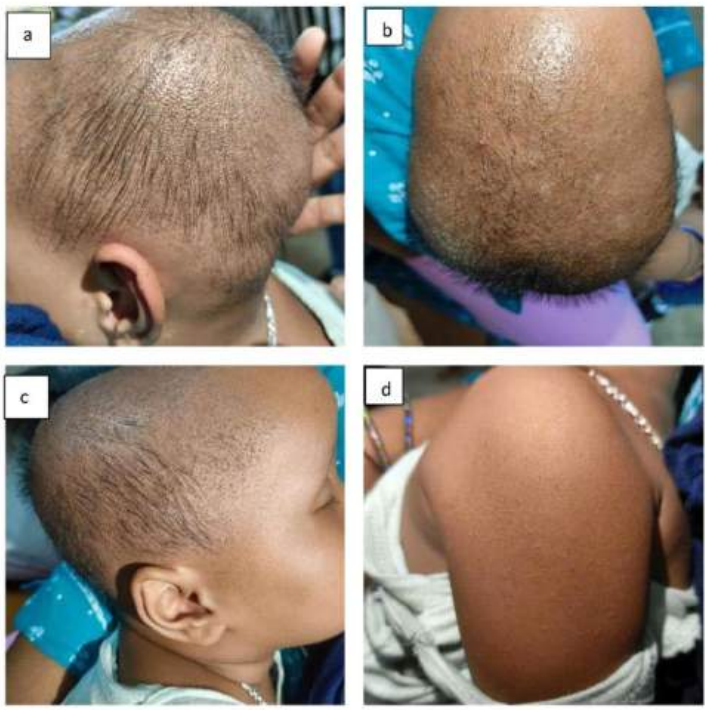

Figure 1: follicular keratotic papules present over scalp and upper arms

On examination, sparse hair was noted over the scalp and medial eyebrows, with hair loss more marked over the fronto-parietal region and lateral eyebrows; hair was absent over other body parts. Multiple keratotic papules studded the scalp, upper back and proximal upper limbs. Teeth and nails were unremarkable. Dermoscopy revealed multiple regularly spaced white spots producing a characteristic "cluster of stars" pattern, interspersed with irregularly arranged black dots. Histopathology of a 3 mm scalp punch biopsy showed mildly acanthotic epidermis with dilated follicular ostia and infundibula, few functional hair follicles, and multiple non-functional follicles with central keratin-filled cysts in the dermis; adnexal structureswereotherwisen o r m a l . Biochemical parameters, including serum calcium, phosphate, vitamin D3, parathormone and alkaline phosphatase, were all within normal limits. Based on the revised diagnostic criteria proposed by Yip et al, a final diagnosis of congenital atrichia with papular lesions was made.

Congenital atrichia with papular lesions is a rare, commonly misdiagnosed disorder attributed to mutations in the hairless gene on chromosome 8p21.2, which encodes a zinc finger transcription factor involved in regulating catagen remodelling of the hair cycle; loss of function leads to extensive apoptosis of hair matrix cells. Specific missense mutations and single base-pair deletions produce a heterogeneous phenotype depending on the gene segment affected. The disease characteristically presents with irreversible hair loss within one to two months of birth, involving the scalp, eyebrows and eyelashes, with axillary and pubic hair affected after puberty. Keratotic papules, representing non-functional hair follicles with mid-dermal keratin-filled cysts, are seen extensively over the body. The dermoscopic "cluster of stars" appearance was first described by Chandrashekar et al in a case report of APL.

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The closest differential is vitamin D-dependent rickets type IIA, in which mutations in the vitamin D receptor (VDR) gene — which also encodes a zinc finger transcription factor — produce a strikingly similar phenotype, as described by Miller et al, implicating the VDR gene product in hair cycle regulation. Other differentials include alopecia universalis, congenital atrichia and ectodermal dysplasias. The presence of papular lesions and non-response to therapy argues against alopecia universalis and congenital atrichia, while the absence of hair, nail or dental anomalies rules out ectodermal dysplasia. Four of the five major criteria in the revised diagnostic scheme of Yip et al — presence of hair at birth with rapid shedding within the first few months without spontaneous regrowth, association with extensive milia-like cysts over the scalp and trunk, corroborative histology demonstrating dilated hair follicles with keratin-filled cysts, and resistance to conventional treatment — supported the diagnosis in this case.

In conclusion, awareness of this clinical entity is important for early and accurate diagnosis — not because it alters prognosis, but because it protects the patient from unnecessary treatments and their side effects, and spares caregivers from false hopes and avoidable treatment costs.

Figure 2

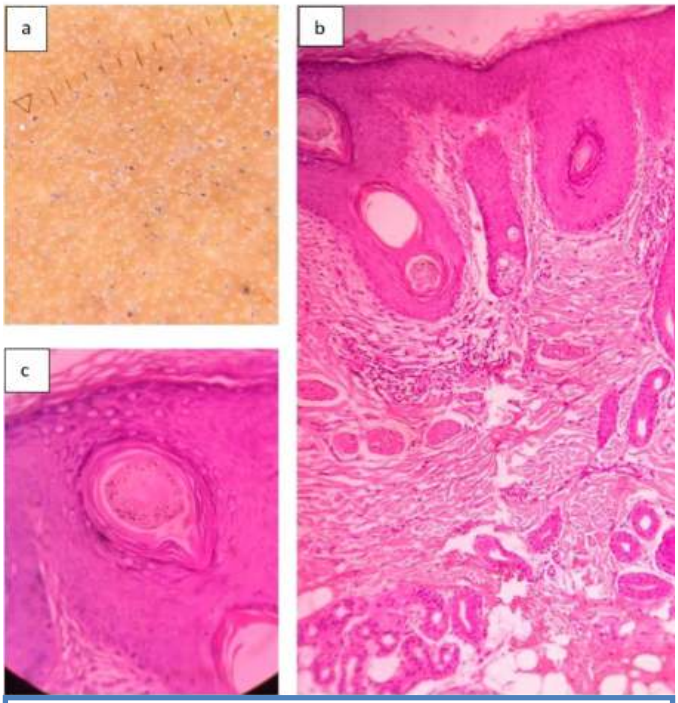

Figure 2: (a) dermoscopy shows "cluster of stars"appearance. (b),(c): histopathology shows multiple dilated hair follicles filled with keratinous material

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Monthly Clinical Meeting of IADVL WB on 28/07/2026 at IPGMER & SSKM Hospital, Kolkata

On July 28, 2026, the Department of Dermatology at IPGMER and SSKM Hospital hosted the monthly clinical meeting, a highly beneficial educational initiative organized by IADVL West Bengal. The academic session was expertly chaired by Prof. Dr. Biswanath Naskar. The discourse was further enriched by the active participation of esteemed faculty members, including Dr. Kakali Mridha, Head of the Dermatology Department at SSKM, along with Dr. Falguni Nag, Dr. Tirthankar Gayen, Dr. Somashree Dutta, Dr. Kisalay Ghosh, and Dr. Subhamoy Neogi.

This clinical meeting served as an invaluable platform for Post Graduate Trainees and provided them a unique opportunity to review challenging diagnostic scenarios, explore rare dermatoses, and refine patient management strategies under the guidance of senior experts.

The following clinical cases were presented and discussed during the session:

- *Familial presenile sebaceous hyperplasia — presented by Dr. Arindam Sarkar*
- *Bazex-Dupré-Christol syndrome — presented by Dr. Arunima Laha*
- *Reactive perforating collagenosis in a case of anti-synthetase syndrome — presented by Dr. Sahadiya VP*
- *Reed's syndrome — presented by Dr. Arka Pramanik*
- *Cutaneous IgG4-related disease — presented by Dr. Ananya Roy*
- *Atrichia with papular lesions — presented by Dr. Anisha Das*
- *Chromoblastomycosis — presented by Dr. Lengu U Mero*
- *Heck's disease — presented by Dr. Tamali Mondal*
- *Dermatofibrosarcoma protuberans — presented by Dr. Ballavi Das*
- *Spotted grouped pigmented nevus — presented by Dr. Dhara Das*

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IADVL SIG Pediatric Dermatology: 19th July 2026 at Taj Bengal, Kolkata
CME on Current Concepts in Pediatric Dermatology: Evidence to Practice

The IADVL Academy, in association with the IADVL West Bengal Branch and SIG Pediatric Dermatology, convened a comprehensive CME titled "Current Concepts in Pediatric Dermatology: Evidence to Practice" on Sunday, the 19th of July, 2026 at the Taj Bengal in Kolkata.

The day commenced with an Inaugural ceremony featuring a Welcome Address by Dr. Kingshuk Chatterjee, Vice President, an Address by Dr. Somenath Sarkar (Hon. Secretary, IADVL WB), and Opening Remarks by Dr. Soumya Jagadeesan (Convenor, SIG PD), culminating in the traditional Lamp Lighting by all dignitaries.

The meticulously curated scientific programme addressed both foundational treatments and complex, systemic presentations through a variety of engaging formats. The initial session, chaired by Dr. Manas Chatterjee, provided rapid, focused insights into the management of childhood cases. Topics ranged from alopecia areata (Dr. Rohan Barua) and molluscum contagiosum (Dr. Harsha Sarawgi) to diaper dermatitis (Dr. Shahrukh Raza), extensive psoriasis (Dr. Titli Ghosh), acanthosis nigricans (Dr. Sharmistha Panja), and twenty nail dystrophy (Dr. Dyuti Das).

Dr. Kingshuk Chatterjee led a dedicated session navigating the nuances of ethics in pediatric dermatology practice. This was followed by an Open Forum featuring a presentation on the role of dermatopathology in pediatric dermatoses by Dr. Somenath Sarkar, and a robust panel discussion on difficult-to-treat conditions moderated by Dr. Manas Chatterjee. The esteemed panelists for this session included Dr. Aditi Chakrabarti, Dr. Ameli Sarkar, Dr. Aparajita Ghosh, Dr. Anirban Mukherjee, and Dr. Bhaskar Dutta.

Exploring complex diagnostic territories, Dr. Feroze Kaliyadan presented recent advances in childhood vitiligo, while Dr. Anupam Das provided an overview of mosaic disorders. A case-based panel discussion on hyperpigmentation and hypopigmentation followed, expertly moderated by Dr. Abhijit Saha, featuring panelists Dr. Sujata Sengupta, Dr. Saswati Halder, Dr. Indrashis Podder, Dr. Somodyuti Chandra, and Dr. Nazish Naiyer.

Highlighting the critical overlap between pediatric presentations and deeper systemic implications, this session featured Dr. Sudip Kr. Ghosh outlining auto-inflammatory syndromes and Dr. Shreya Poddar discussing the current standing of metabolic syndrome in pediatric dermatology. Dr. Soumya Jagadeesan also covered mistakes to avoid in pediatric therapeutics, alongside a talk on newer entities by Dr. Partha Mukherjee.

The scientific sessions concluded with a spirited debate on whether targeted therapies will replace other molecules in the treatment of atopic dermatitis. The engaging face-off featured Dr. Sk. Shahriar Ahmed and Dr. Sambit Chatterjee, with Dr. Saumya Panda serving as the moderator.

The highly successful academic event officially wrapped up with a Valedictory Session, where Dr. Sumit Sen, Chairperson of the IADVL WB Academy, delivered key take-home messages and the Vote of Thanks.

The CME concluded on a high note with 104 delegates in attendance








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Report of Activities of IADVL WB
Bankura & Purulia District Chapter (April-June 2026)

A comprehensive Continuing Medical Education (CME) program was convened in Durgapur on the 11th of June, bringing together a robust academic cohort. The event witnessed enthusiastic participation from senior dermatologists, medical college faculty members, postgraduate residents, and consultant dermatologists from across the Durgapur region.The academic proceedings featured the following key sessions:

Advances in Acne Management: Dr. Jayanti Datta delivered an insightful presentation on the emerging role of trifarotene, detailing its targeted efficacy and clinical utility in the management of acne.

Therapeutic Frontiers: Dr. Anmol led a focused academic session exploring the clinical applications and evolving role of upadacitinib in dermatological practice.

Postgraduate Clinical Case Discussion: Enhancing the academic rigor for the residents in attendance, Dr. Sudipta Roy conducted an in-depth, interactive case discussion on leprosy. This session provided critical clinical pearls and practical insights into the management of complex presentations.

The CME served as an excellent platform for regional knowledge exchange, successfully bridging the gap between recent pharmacological advancements and practical, case-based learning.

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A Continuing Medical Education (CME) program was convened at the Department of Dermatology in Purulia on the 30th of June. The academic gathering saw strong attendance from the Head of the Department, senior dermatologists, faculty members, posted interns, and house staff of Deben Mahata Government Medical College.

The scientific agenda highlighted the expertise of talented young dermatologists, offering a dynamic and engaging academic experience. The proceedings featured the following key sessions:

Clinical Insights into Xanthoma: Dr. Dipra Biswas, Assistant Professor, delivered a focused presentation on Xanthoma, exploring its clinical manifestations and diagnostic significance.

Perspectives on Leprosy: Dr. Tamanna Dokania, Senior Resident, led a comprehensive academic session on Leprosy, reinforcing crucial clinical perspectives and disease management principles.

Diverse Dermatoses: Dr. Sneha Chakraborty, House Staff, conducted an engaging session covering both tattoo granuloma and porokeratosis, adding valuable morphological and diagnostic depth to the day's clinical discussions

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DERMAGINATIONS:
PAGING PASSION BEYOND PRACTICE

HAVE YOU

Dr. Aniruddha Ghosh
Prof JIMSH

Have you ever cried
Cried at night?
Cried seeing a picture
That very sight.

Have you ever wondered
Of the long lost time?
Spend with the person most valued
Who now dont give a dime.

Have you ever shed a tiny drop?
A tear from your eye.
Have you ever shouted
Or uttered a silent cry?

Have you ever felt all alone
Someone tearing at your heart.
Have you missed someone
Who, in your life has now no part.

Have you stared at thin air
At nothingness at all?
Have you ever wondered how days slipped by
From summer to winter fall?

Have you grasped for breath
Clutching at thin air.
Have you looked at your lost memories
Did you ever dare?

Take it from me
Trust me if you can.
There is no god.
There is no heavenly plan.

Its all what you do
That comes back to haunt you.
Grasp your chances with your hand
For they r so very few.
Try not to look back
It'll only cause you pain.
Future is all there is
Past holds no gain.

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Quiz Zone

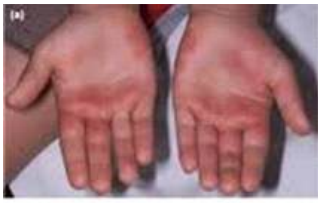
1) *S' is a patient of aplastic anemia on G-CSF therapy. 2 days later she developed erythematous tender plaques over bilateral palms and soles extending onto the extensor surface of forearms and legs. Lesions were bilaterally symmetrical and associated with fever. Study figure 1 and provide the diagnosis.*

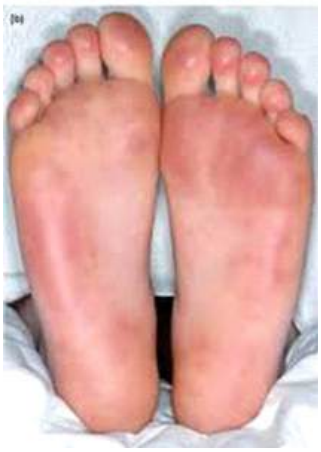
2) *Patient ' B' came to the OPD with a non healing ulcer over his right foot with a history of trauma while swimming in a pond. The ulcer was mildly painful with greenish exudate, non responsive to antibiotic therapy. Microscopy of pus revealed the organism as depicted in figure 2. Identify the infection.*

3) *B' presented to the OPD with multiple folliculocentric papules over his upper back and forearms(figure 3) which were not responding to the therapy he was on for truncal acne. The lesions were non scaly and smooth to touch. VVG staining of a biopsy obtained from the papule showed marked loss of elastic tissue in a perifollicular distribution. Identify the condition*

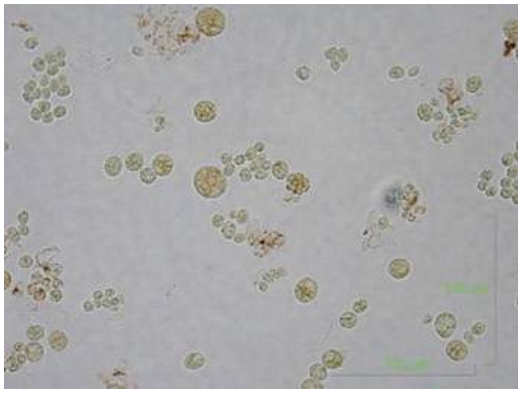
4) *Combining his love for dermatology and physics this personality was instrumental in developing the working priniciple of lasers in dermatology. Identify the famous personality (figure 4) and state his claim to fame.*

5) *Identify this classical histopathological finding (figure 5) and the disease classically associated with this finding.*

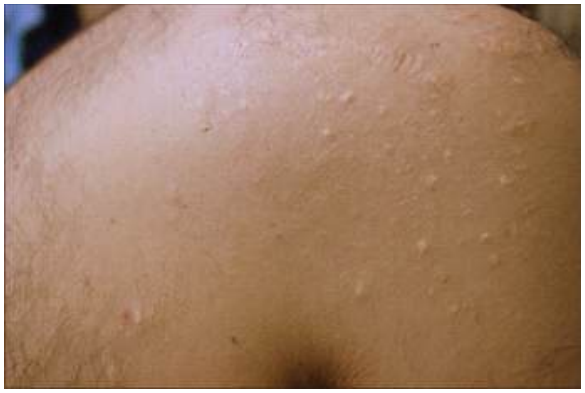




[fig 1]

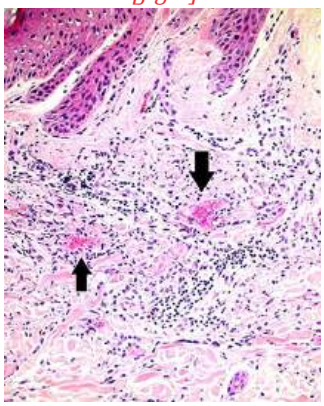


[fig 2]



[fig 3]

[fig 4]



[fig 5]

The correct response given: Dr. Shatanik Bhattacharya for Dermawiz

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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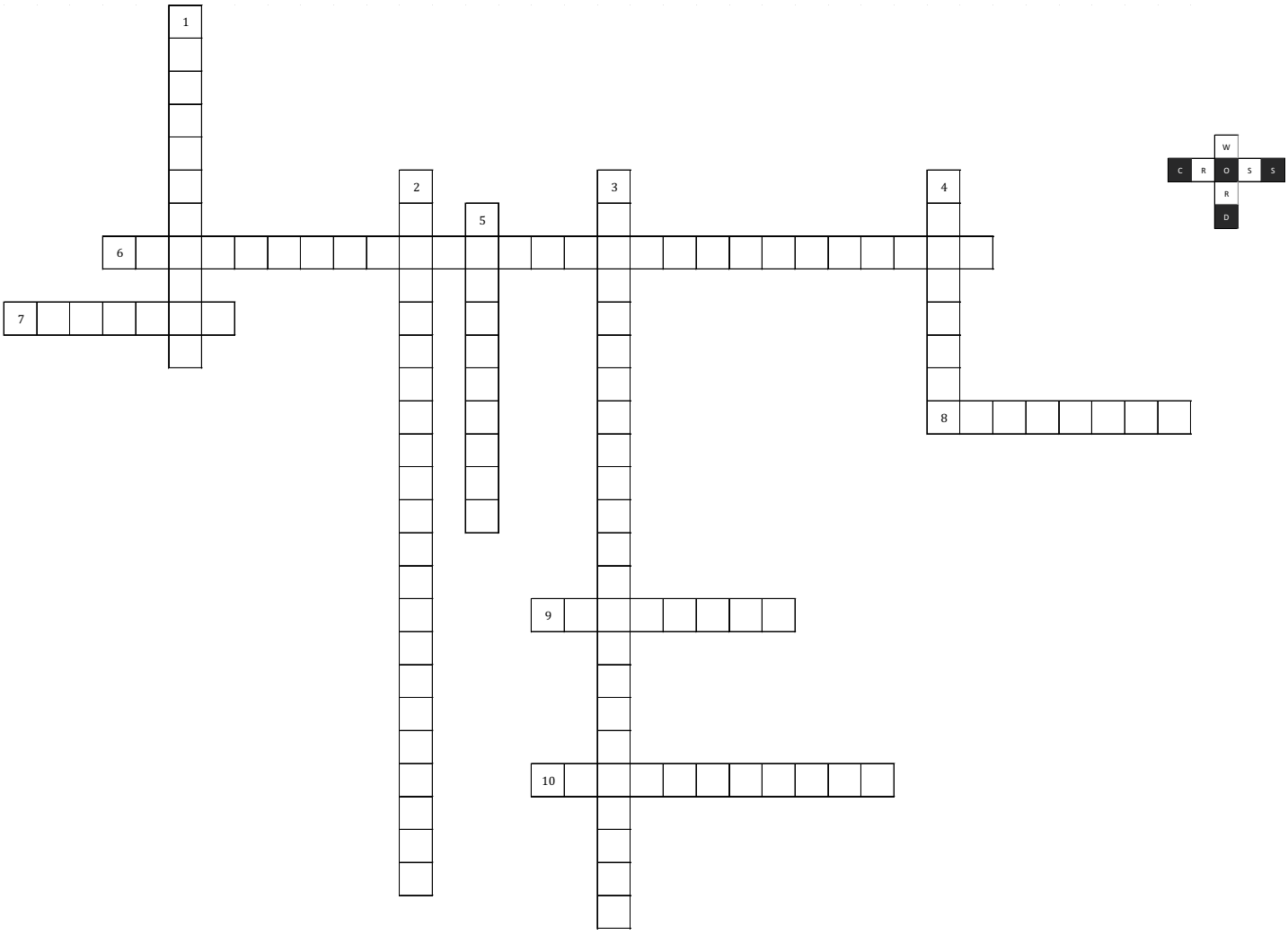
Brainstorm

Across

6. Marquee sign in HPE
7. Technique of choice in Mesotherapy
8. Type of Aplasia cutis with fetus papyraceus or placental infract
9. Topical drug in Epidermolysis bullosa simplex inhibits Interleukin 1β
10. Source: Clitopilus scyphoides

Down

1. Next generation Anti- IgE for chronic Urticaria
2. Schmidt"s Triad
3. Ravelled wool appearance in HPE
4. Tool for diagnosis and threshold testing of symptomatic dermographism
5. Frog Spawn appearance in dermoscopy



Quiz Answer Volume-4, Issue-3

Q1. A. Multiple endocrine neoplasm 2A syndrome.
B. RET proto-oncogene.

Q2. Sebetralstat. (It is the first oral on-demand medication approved for treating acute attacks of hereditary angioedema in individuals more than 12 years age)

Q3. Secukinumab (SUNRISE & SUNSHINE trial for hidradenitis suppurativa).

Q4. Treponema pallidum (Two German scientists Fritz Schaudinn & Erich Hoffmann discovered this bacterium in 1905)

Q5. Morse-code sign in Tinea capitis.

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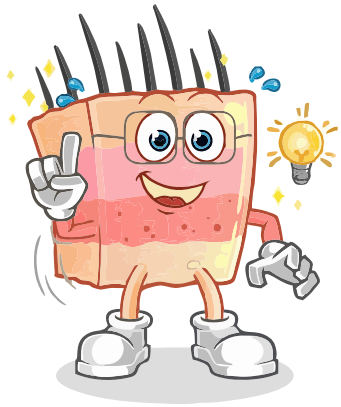
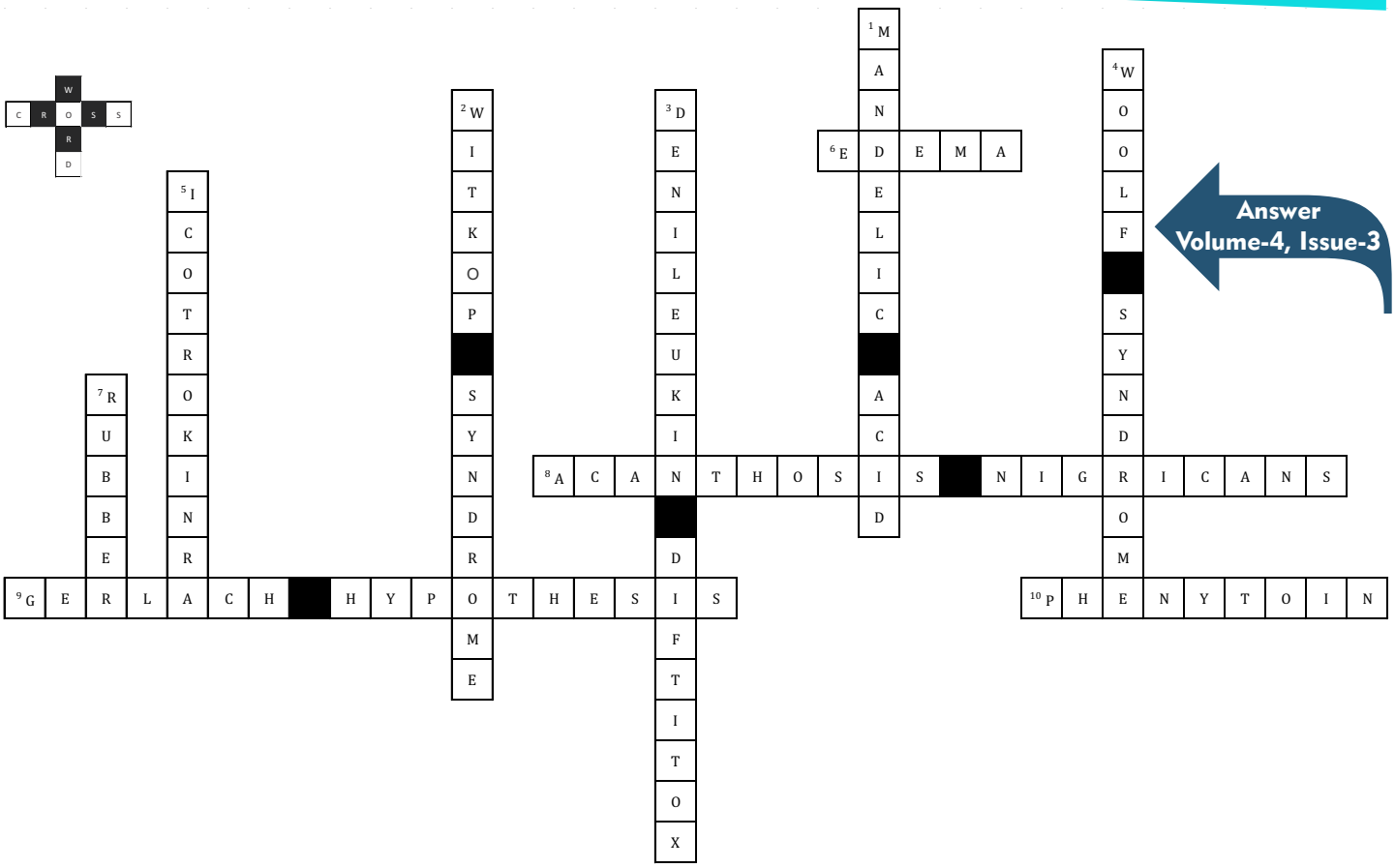


Dermwiz

I wear no curl by nature's choice,
Yet roughened whispers are my voice.
Along my shaft, not at my root,
My silent weakness takes its route.
A careless touch, a heated art,
May tear my fragile frame apart.
Some inherit what others acquire,
Through genes, or combs, or curling fire.
Beneath the lens two warriors meet,
Their shattered lances incomplete.
A brush-like clash, a fraying scene,
Where strength once stood, now lies between.
I do not fall before my time,
I simply break before my prime.
Tell me, what disorder bears this name?

Dermwiz Answer
Volume-4, Issue-3

PYODERMA GANGRENOSUM



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1973
WEST BENGAL STATE BRANCH

Dermazone east Cuticon wb 2026

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

27th, 28th & 29th November 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

ABSTRACT DEADLINE:
15th October, 2026

EARLY BIRD REGISTRATION ENDS:
31st July 2026

OPPORTUNITIES FOR PGs

1. Award paper session
2. Quiz
3. Extempore
4. More Award Opportunities in e poster (every 10 e-poster having certificate of excellence)
5. Opportunity to earn best college award for your institution

HANDS-ON LEARNING

- Dermatopathology
- Procedural Dermatology
- AI in Dermatology

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