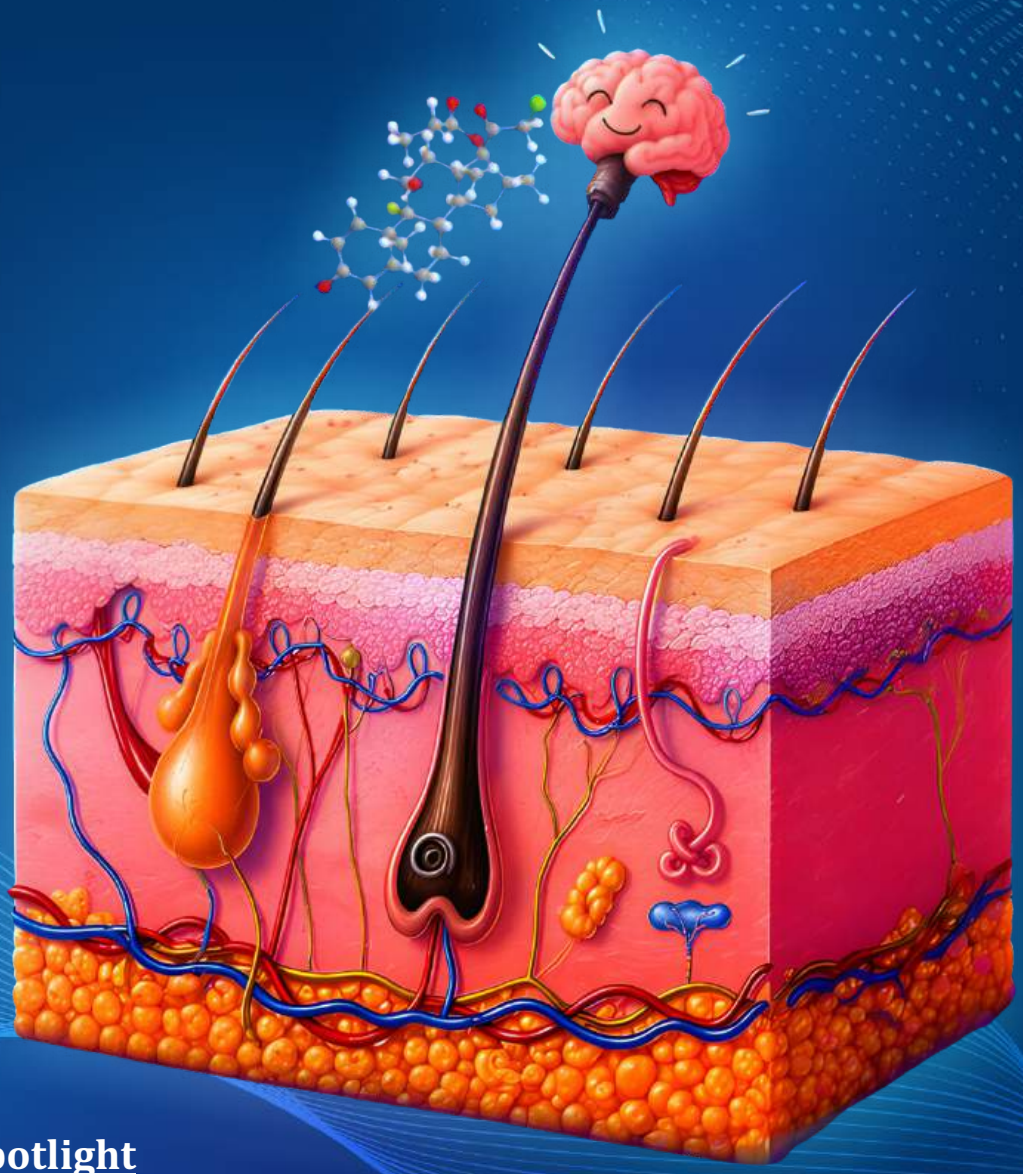
Indian Association of Dermatologists, Venereologists & Leprologists West Bengal State Branch

SKINTELLECT

The Official Newsletter of the IADVL West Bengal State Branch



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

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Note from the President

Warm Greetings on behalf of IADVL WB to all our members.

At the outset I would like to pay respects to the departed soul of Dr Shreya Poddar, the first editor of Skintellect, who left for her heavenly abode at such a tender age recently. I pray to God that he gives strength to the bereaved family to bear this irreparable loss. It's a great loss to our fraternity as well given the exceptional academic heights she achieved at such a short time.

In the second half of the year we are well in course to continuing effectively with the declared academic and social activities. Two SIGs in the form of 'Dermatology Clinical Research (DCR) and 'Recent advances in Psoriasis' were held on the 16th and 30th of August respectively. They were stupendous successes given their academic content delivered by eminent National and State faculties. I would like to appreciate the efforts put in by the State coordinators Dr Shahriar Ahmed and Dr Abhishek De to make the above SIGs a lot of success. I would have loved to see more participants/delegates attending these academic endeavors of both the National IADVL Academy and IADVL WB.

Dr Sujata Sengupta and her team comprising of Dr Arijit Coondoo, Dr Aditi Chakraborti and Dr Aarti Sarda did a fabulous job conducting a medical camp at an Old Age Home on the 30th of August examining and distributing medicines and moisturizers amongst the very senior citizens of the Home.

I would also like to appreciate the efforts of our office staff Dr Khageswar Das and Diptanshu Paul who meticulously arranged for all the certificates and other logistics for all the above events.

We had a fruitful Mid Term CC Meeting of the IADVL at New Delhi on the 22nd and 23rd of August 2026 where we put forward our request for the PLM to LM conversion of those PLMs whose deadline to convert to LM has expired. The HSG assured us she would look into the matter for those PLMs who had written to IADVL within the stipulated period of 7 years. I would take this opportunity to request all the residents passing out that you please go ahead with the procedure as soon as you receive the necessary documents soon after passing your MD DVL exams. I would also request the faculties at different Medical Colleges in our State to urge their residents to convert to LMs at their earliest so that they continue to receive the benefits of our association uninterruptedly. Our Hony Secretary Dr Somenath Sarkar also put forward the issues we are facing with the logistical and financial aspects of different SIGs being held in West Bengal so that we do not face any burden.

I wish all the members and their families a healthy and prosperous year ahead.

With warm regards.

Long Live IADVL.

Jai Hind.

Dr. Arghyaprasun Ghosh
President
IADVL WB

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Secretary's Scribes

Dear Esteemed Members of IADVL West Bengal,

It gives me immense pleasure to connect with you through the 5th issue of Skintellect, the newsletter of IADVL West Bengal. It is heartening to see Skintellect continuing to grow as a platform for academic exchange, professional updates, and communication among our members.

The past few months have been particularly fulfilling for our State Branch. We successfully conducted the SIG Dermatology Clinical Research Programme and the SIG Psoriasis Programme in Kolkata. Both programmes witnessed enthusiastic participation and meaningful academic interaction, reflecting the strong commitment of our members towards continuing medical education and advancement in dermatological practice.

Our State Branch also had the opportunity to participate in the Mid-Term Central Council Meeting at Ghaziabad, where important matters concerning the organisation and the future of dermatology were discussed. Such interactions provide valuable opportunities to exchange ideas, share experiences, and contribute to the larger vision of IADVL.

On the administrative front, I am pleased to share that we have strengthened our State Branch office by recruiting an Office Assistant and an Accounts Assistant. This will help us streamline our administrative and financial activities and provide better support to our members.

I sincerely thank all our office bearers, SIG coordinators, faculty members, organisers, and members for their continued support and active participation. The success of every initiative of IADVL West Bengal is a reflection of our collective effort and unity.

Let us continue to work together with enthusiasm and dedication to make IADVL West Bengal academically vibrant, professionally progressive, and member-centric.

I wish the 5th issue of Skintellect every success and hope that it continues to inspire, inform, and connect our dermatology fraternity.

With warm regards,

Dr. Somenath Sarkar
Honorary Secretary
IADVL WB

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Editors Desk

Dear Readers,

It gives me immense pleasure to welcome you to the August edition of Skintellect.

This month, however, begins on a sombre note. The Skintellect family, along with the entire dermatology fraternity, mourns the untimely passing of Dr. Shreya Poddar, who left us for her heavenly abode on 18 August 2026, far too soon and at such a young age. Her warmth, kindness, and gentle presence touched many lives and will remain fondly etched in our memories. We extend our deepest condolences to her family and loved ones. May her soul rest in eternal peace, and may her family find strength and solace in this difficult hour.

Amidst this moment of remembrance, the month continued to be enriched by a vibrant academic calendar under the aegis of IADVL West Bengal. We witnessed two stimulating Special Interest Group (SIG) programmes, dedicated to Clinical Research and Psoriasis, bringing together valuable insights, meaningful discussions, and shared learning. Our monthly Clinical Meet, hosted by Malda Medical College, was conducted in a hybrid format, providing an opportunity for colleagues to connect and learn both in person and virtually. An outstandig camp activity was oragnised by IADVL WB at an old age home where moisturizers and medicines were also distributed.

This edition brings with it a diverse blend of knowledge, experience, and creativity. In our Dermatologist on Spotlight section, Dr. Suchibrata Das graciously shares his invaluable experiences and perspectives with our readers. The DermBuzz column features an insightful article by Dr. Dyuti Das on the often-overlooked yet clinically relevant subject of non-dermatophyte onychomycosis.

Our Residents' Corner features Dr. Romika Saharan, who takes us through the fascinating world of toponyms in dermatology, uncovering the stories and origins behind some of the names we encounter in our everyday dermatological practice. In the Case Podium, Dr. Sarada Bandyopadhyay presents an intriguing case of granuloma inguinale masquerading as esthiomene, reminding us once again of the importance of clinical curiosity and diagnostic acumen.

Adding colour and creativity to this edition, Dr. Nirjhar Mondal shares a beautiful painting in our Creative Corner, offering us a refreshing pause from the academic world.

As always, we hope this edition of Skintellect informs, inspires, and sparks curiosity among our readers. Thank you for continuing to be a part of our journey as we strive to bring together the academic, clinical, and creative facets of dermatology.

Happy Reading!

Warm regards,

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

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CONDOLENCE MESSAGE

Dr. Shreya Poddar

With a heavy heart, we, on behalf of the IADVL West Bengal State Branch, express our profound grief and sorrow at the untimely demise of our dynamic young life member [LM/WB/11354], Dr. Shreya Poddar.

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

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

With deepest sympathy,

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DERMATOLOGIST SPOTLIGHT: DR. SUCHIBRATA DAS

1. *Your journey in dermatology spans several decades of dedicated clinical practice and academic leadership. Looking back, what have been the most defining moments of your career?*

   Looking back, it is difficult for me to identify a single "most defining moment." My journey has been shaped by a few important turning points.

   *Coming from a rural background, I began my medical career with a strong inclination towards **Medicine and its allied subjects**. During my undergraduate training at Burdwan Medical College and IPGME&R, Kolkata, my exposure to General Medicine, Paediatrics and Cardiology strengthened this interest. I still remember caring for critically ill patients with complete heart block, stabilising them with temporary pacing while awaiting permanent pacemaker implantation. Those experiences left a lasting impression on me.*

   *However, life took me in a different direction. I was fortunate to join **AIIMS, New Delhi, in Dermatology**. That was an important turning point in my professional life.*

   After completing my postgraduate training, I returned to service and worked as a Specialist Dermatologist in both teaching and peripheral government hospitals. Later, I moved to the Medical Education Service. Looking back, I consider this perhaps the most defining phase of my life, as it marked the beginning of my journey as a teacher.

   *Yet, I have always considered myself a **student first**—continuously learning, unlearning and growing through every stage of this journey.*

2. *Psoriasis and autoimmune bullous disorders have remained your areas of special interest. What continues to fascinate you about these diseases, and where do you see the future of their management heading?*

   Skin is not merely an external organ but a dynamic immunological interface and that relatively subtle changes at the molecular level can produce profound clinical manifestations, at a same time considerable impact on quality of life. Psoriasis and autoimmune bullous disorders sit at the intersection of immunology, genetics, clinical medicine and human experience. These continue to fascinate me.

   When I started my dermatology journey, psoriasis was a merely a clinical entity, and that much was known, activated T lymphocytes in the dermis and epidermis directed the inflammatory process. I am particularly fascinated by the evolving understanding of the immune pathways involved and how this has transformed our approach from simply controlling symptoms to targeting specific disease mechanisms. In autoimmune bullous disorders, the elegance of correlating clinical morphology with immunopathology and immunological investigations remains immensely rewarding. At the same time, these diseases teach us that successful treatment is not only about achieving skin clearance or controlling blister formation—it is also about restoring confidence, function and quality of life.

   *Looking ahead, I believe the future of management will increasingly be driven by **precision medicine**. We are moving towards better identification of disease endotypes, biomarkers that can predict treatment response, more targeted immunomodulation and increasingly individualized therapeutic strategies. Artificial intelligence and digital dermatology may further assist in early diagnosis, monitoring disease activity and assessing treatment response.*

   *But, I believe the dermatologist's role will remain central. The future will not simply be about having more sophisticated drugs; it will be about **choosing the right treatment for the right patient at the right time**.*

3. *You have successfully balanced academic responsibilities as a Head of Department with a busy clinical practice. What has been your guiding philosophy in maintaining excellence in both domains?*

   I have always believed that academic medicine and clinical practice are not two separate responsibilities; rather,

they strengthen and enrich each other. My guiding philosophy has been to remain a clinician first, while ensuring that teaching, academic work and departmental leadership remain closely connected to patient care.

As a Head of Department, I have tried to lead by example—to remain accessible to patients and students, to encourage my colleagues and younger faculty members, and to create an environment where learning and clinical excellence go hand in hand. Clinical practice keeps us grounded in the realities of patient care, while academics gives us the opportunity to question existing practices, generate new knowledge and pass it on to the next generation.

Excellence does not come from trying to do everything personally. It comes from building a strong team, delegating responsibly, respecting the strengths of colleagues and nurturing younger doctors to take ownership and grow. Time management, discipline and consistency are important, but so are the ability to adapt and the willingness to keep learning.

*My philosophy is quite simple: whatever responsibility we undertake—**whether treating a patient, teaching a student, conducting research or leading a department—it should be approached with sincerity, competence and a sense of responsibility**.*

4. *You are widely respected not only for your clinical expertise but also for your unwavering commitment to ethical medical practice. What values do you believe should never be compromised, irrespective of changing times?*

*For me, certain values in medicine are timeless and should never be compromised, irrespective of how rapidly medicine, technology or society changes. At the foremost is **integrity**—being honest with our patients, our colleagues and, equally importantly, with ourselves. I must have the courage to acknowledge uncertainty, admit a mistake when it occurs and always place the patient's welfare above personal or professional considerations.*

*Every patient deserves to be heard with **Compassion**, and treated with respect, regardless of their social or economic background.*

*I also believe that **evidence-based practice and continuous learning** are ethical responsibilities. Medical knowledge is constantly evolving, and we have a duty to update ourselves*

*The fundamental trust between a patient and a doctor must remain sacred. **Professionalism , confidentiality, fairness and accountability help to maintain such**, irrespective to progress in technology, therapeutic option or healthcare system.*

*For me, the essence of ethical medicine is simple: **treat every patient as a person first, make decisions with integrity, and never allow personal interest to come before the patient's best interest**. These principles define the profession itself.*

5. *The teachings of Sri Ramakrishna have been an important source of inspiration in your life. How have these principles influenced your approach to medicine, teaching, and leadership?*

*I do not have the audacity to claim that I truly follow Thakur Sri Ramakrishna. I can only humbly say that, within my very limited capacity, I try to live by His teachings—especially the values of **compassion, humility, selfless service, and respect for every human being**. I have always felt that these principles have a natural place in medicine, where our profession ultimately revolves around serving people at some of the most vulnerable moments of their lives.*

In my approach to medicine, this has meant trying to look beyond the disease and see the individual who is suffering. A patient may come to us with a dermatological problem, but behind that problem there may be anxiety, loss of confidence, social stigma or personal distress. The practice of medicine therefore requires not only knowledge and clinical skill, but also empathy and the ability to listen.

As a teacher, I have tried to regard teaching as a form of service. Medical education is not simply about transferring

information; it is about helping young doctors develop competence, judgement, compassion and a sense of responsibility towards their patients. Our knowledge and experience becomes truly meaningful when we are able to share it with the next generation.

***Humility over authority and service over position** is the way of my leadership. The message, thtt I try to follow, is **"Shiva Jnane Jiva Seva", service to humanity is service to the Divine**. I do not claim to practise these ideals perfectly, but they have provided me with an inner compass throughout my professional journey—and continue to remind me that medicine is, at its heart, a profession of service.*

6. *Over the years, you have earned the trust of generations of patients. What, in your opinion, is the true foundation of a lasting doctor–patient relationship?*

   *In my experience, the true foundation of a lasting doctor–patient relationship is **trust**. And trust is not established by a single consultation; it is built gradually through honesty, consistency, competence and genuine concern for the patient.*

   A patient wants to feel that the doctor is not merely treating a disease, but is listening to the person who is experiencing it. I have always believed that listening is one of the most important clinical skills.

   Medicine does not always offer immediate answers or guaranteed outcomes. Explaining the diagnosis, the available options, the limitations of treatment and the possible uncertainties in a clear and understandable manner helps patients to establish realistic expectations. In dermatology, this becomes particularly important because many skin disorders are chronic, recurrent or visibly distressing.

   *Every patient, irrespective of age, background or social circumstances, deserves to be treated with dignity. **Respect must be unconditional**.*

   Ultimately, a lasting doctor–patient relationship is built when a patient feels, "My doctor understands me, is honest with me, and will stand by me."

7. *If you could offer one piece of advice to the next generation of dermatologists—about clinical excellence, and personal fulfillment—what would it be?*

   *If I could offer one piece of advice to the next generation of dermatologists, it would be this: **never stop learning, but never lose sight of the person behind the disease**.*

   Dermatology is advancing at an extraordinary pace, with new insights into immunology, genetics, therapeutics, technology and artificial intelligence. It is important to remain curious, question what we know, keep ourselves updated and develop strong clinical skills. But clinical excellence is not achieved by knowledge alone. It comes from careful observation, listening to patients, sound clinical judgement and the humility to recognize when we need to learn more.

   At the same time, I would encourage young dermatologists not to measure success only by degrees, publications, procedures or professional positions. These have their place, but lasting professional fulfilment comes from the difference we make in the lives of our patients and students. Remain compassionate, maintain your integrity, value your colleagues and make time for your family, interests and inner life.

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DERMBUZZ : NON-DERMATOPHYTE ONYCHOMYCOSIS: DIAGNOSIS, DILEMMAS, AND MANAGEMENT

Dr. Dyuti Das
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Introduction

Onychomycosis remains one of the most frequently encountered nail disorders in dermatological practice, accounting for nearly 50% of all nail diseases. While dermatophytes have traditionally been regarded as the primary causative organisms, there has been a growing recognition of the role of non-dermatophyte fungi in nail infections. Improved laboratory techniques, increasing clinical awareness, and changing epidemiological trends have collectively contributed to the identification of non-dermatophyte onychomycosis (NDO) as a distinct and clinically significant entity.

Despite these advances, NDO continues to challenge dermatologists. The ubiquitous nature of many non-dermatophyte fungi raises an important question: does a positive culture represent true infection or merely laboratory contamination? Furthermore, the absence of standardized diagnostic criteria and evidence-based treatment protocols often complicates clinical decision- making.

This article reviews the current understanding of NDO, highlighting the diagnostic challenges, therapeutic dilemmas, and practical management strategies relevant to contemporary dermatological practice.

Understanding Non-Dermatophyte Onychomycosis

Non-dermatophyte onychomycosis refers to nail infections caused by molds and yeasts other than dermatophytes. Although once considered uncommon, non-dermatophyte fungi are now estimated to be responsible for 10–20% of all cases of onychomycosis, with some studies reporting considerably higher rates in tropical and subtropical regions.

The most frequently implicated organisms include Aspergillus species, Fusarium species, Scopulariopsis brevicaulis, Acremonium species, Alternaria species, and Neoscytalidium species. Yeasts, particularly Candida albicans, Candida parapsilosis, and Candida tropicalis, are also recognized as important pathogens.

Several predisposing factors contribute to the development of NDO, including advanced age, diabetes mellitus, immunosuppression, peripheral vascular disease, repeated exposure to moisture, nail trauma, and pre-existing nail abnormalities. Unlike dermatophyte infections, non- dermatophyte fungi frequently colonize previously damaged nails, suggesting that disruption of the nail barrier is a key factor in disease development.

Clinical Presentation

The clinical manifestations of NDO are often indistinguishable from those of dermatophyte onychomycosis. Distal and lateral subungual onychomycosis remains the most common clinical presentation and is typically characterized by subungual hyperkeratosis, onycholysis, and nail discoloration.

Superficial white onychomycosis has been associated more commonly with Aspergillus and Fusarium species, whereas chronic paronychia accompanied by nail dystrophy may suggest candidal infection. However, clinical appearance alone rarely provides sufficient information to identify the causative organism accurately.

The lack of distinguishing clinical features reinforces the importance of laboratory confirmation before initiating treatment.

The Central Diagnostic Dilemma: Infection or Contamination?

Perhaps the greatest challenge in diagnosing NDO is differentiating true infection from contamination.

Non-dermatophyte molds are widely distributed in the environment and are commonly found in soil, water, and decaying vegetation. Consequently, the isolation of these organisms from nail specimens does not automatically establish a diagnosis of onychomycosis.

This distinction has important therapeutic implications. Misinterpreting a contaminant as a pathogen may expose patients to prolonged systemic antifungal therapy, unnecessary laboratory monitoring, and avoidable adverse effects.

Therefore, the diagnosis of NDO should never be based on culture results alone.

Diagnostic Approach

Direct Microscopy

Potassium hydroxide (KOH) examination remains an important first-line investigation.

Direct microscopy allows the visualization of fungal elements within the nail specimen and may reveal:

- *Septate hyphae*
- *Irregular fungal structures*
- *Yeast cells*
- *PseudohyphaeAlthough KOH examination is inexpensive and readily available, it cannot identify the fungal species.*

Fungal Culture

Fungal culture remains the standard method for species identification. However, culture results must be interpreted cautiously because many non-dermatophyte fungi are common environmental contaminants.

Repeated isolation of the same organism from independently collected specimens significantly increases the likelihood of true infection.

The diagnostic criteria proposed by English continue to provide a useful framework. According to these criteria, the diagnosis of NDO should be supported by multiple findings, including:

- *Positive direct microscopy*
- *Isolation of a non-dermatophyte fungus*
- *Absence of dermatophytes*
- *Repeated isolation of the same organism*
- *Significant fungal growth*

Histopathological Examination

Histopathological examination of nail clippings using periodic acid-Schiff (PAS) staining has emerged as an invaluable diagnostic tool.

PAS staining offers several advantages:

- *Greater sensitivity than fungal culture*
- *Demonstration of fungal invasion within the nail plate*
- *Improved differentiation between infection and colonization*

The combination of direct microscopy, fungal culture, and histopathological examination substantially improves diagnostic accuracy.

Molecular Diagnostics

Recent advances in molecular mycology have expanded the diagnostic options available to clinicians.

Techniques such as polymerase chain reaction (PCR), DNA sequencing, and matrix-assisted laser desorption/ionization time-of-flight mass spectrometry (MALDI-TOF MS) enable rapid and precise species identification.Although these technologies show considerable promise, their widespread implementation remains limited by cost and availability.

Therapeutic Challenges

The management of NDO presents several unique challenges.

Many non-dermatophyte fungi exhibit reduced susceptibility to commonly used antifungal agents. In addition, treatment recommendations are often extrapolated from studies involving dermatophyte infections because large, randomized clinical trials specifically evaluating NDO remain scarce.

As a result, treatment outcomes are often unpredictable, and recurrence rates remain relatively high.

Principles of Management

Confirm the Diagnosis

Treatment should be initiated only after confirming that the isolated organism is responsible for the clinical disease. Repeat culture or additional diagnostic investigations may be necessary in equivocal cases.

Mechanical Debridement

Mechanical reduction of the fungal burden improves drug penetration and enhances treatment efficacy.

Common approaches include:

- *Nail trimming*
- *Curettage*
- *Chemical nail avulsion*
- *Surgical nail avulsion in selected patients*

Topical Therapy

Topical antifungal agents may be appropriate for patients with limited disease or superficial nail involvement.

Available options include:

- *Amorolfine*
- *Ciclopirox*
- *Efinaconazole*
- *Tavaborole*

However, topical monotherapy is generally insufficient in extensive or long-standing infections.

Systemic Therapy

Systemic antifungal therapy remains the cornerstone of treatment in moderate-to-severe disease.

Terbinafine and itraconazole are the most commonly prescribed agents, although treatment should ideally be guided by the identified organism.

Aspergillus infections may respond to either terbinafine or itraconazole, whereas Fusarium infections often require prolonged treatment and may demonstrate limited responsiveness. Scopulariopsis infections frequently necessitate combination therapy, while candidal infections generally respond more favorably to azole-based treatment.

Increasing evidence supports the use of combination therapy involving debridement, systemic antifungal agents, and topical treatment to improve therapeutic outcomes.

Emerging Perspectives

The growing availability of molecular diagnostic techniques is transforming the understanding of fungal nail infections. Improved species identification may facilitate more targeted therapeutic interventions and reduce reliance on empirical treatment.

Similarly, antifungal susceptibility testing may become increasingly important in the management of treatment-resistant infections, particularly as concerns regarding antifungal resistance continue to increase.

Further research is required to establish standardized diagnostic criteria and develop evidence- based treatment guidelines specific to non-dermatophyte fungal infections.

Conclusion

Non-dermatophyte onychomycosis represents an increasingly recognized yet frequently overlooked cause of nail disease. The distinction between contamination and true infection remains the cornerstone of diagnosis and requires a comprehensive clinicomycological approach.

Successful management depends upon careful interpretation of laboratory findings, accurate identification of the causative organism, and the implementation of individualized treatment strategies.As diagnostic technologies continue to evolve, dermatologists will be better positioned to address the complexities associated with these infections and improve long-term patient outcomes.

In the era of precision medicine, the management of non-dermatophyte onychomycosis requires a shift from treating laboratory reports to treating patients through a comprehensive, evidence-based, and organism-directed approach.

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RESIDENT'S CORNER:
WHEN GEOGRAPHY WRITES THE DIAGNOSIS

Dr. Romika Saharan
PGT, 2nd Year
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Indian Toponyms in Dermatology

A resident's guided tour through the disease names that carry India's map inside them

Dermatology carries a fascinating map within its vocabulary. Across India, places, people, occupations, and even traditional objects have left their mark on the names of diseases, clinical signs, stains, and techniques. These names are more than labels, they preserve fragments of medical history, regional practice, and the stories through which dermatology evolved.

A toponym is a term derived from a geographic place name. In dermatology, several disease entities, signs, stains, and techniques carry names of Indian cities, regions, or communities, some reflecting where a condition was first described, some reflecting where it remains endemic, and a few that are conventionally classified as toponyms despite disputed origins. Below is a compiled list, organized by category.

1. Infectious and Inflammatory Conditions

Burdwan Fever *- Burdwan, West Bengal*

A synonym for visceral leishmaniasis (kala-azar), endemic to this region. Caused by Leishmania donovani, characterized by earthy-grey discoloration of the skin, fever, and hepatosplenomegaly.

Calcutta Ulcer *- Calcutta (Kolkata), West Bengal*

An older name for cutaneous leishmaniasis, reflecting the disease's historical association with Calcutta as a center of tropical disease study under British colonial medicine.

Delhi Boil *- Delhi*

Another regional name for cutaneous leishmaniasis, part of a family of place-named terms for the same disease across South and West Asia, alongside Aleppo boil (Syria), Baghdad boil (Iraq), Biskra button (Algeria), Kandahar sore (Afghanistan), and Lahore sore (Pakistan).

Dumdum Fever *- Camp Dum Dum, near Calcutta*

A synonym for visceral leishmaniasis (kala-azar), named after the military cantonment near Calcutta where William Leishman first studied the causative organism, later named Leishmania donovani.

Madura Foot *- Madura (Madurai), Tamil Nadu*

A localized, chronic, suppurative, and deforming granulomatous infection of the foot , now known as mycetoma. First recognized as a distinct disease entity in Madurai, which lent the condition its name.

Indian Tick Typhus *- Maharashtra, Tamil Nadu, Karnataka, Kerala*

A tick-borne rickettsiosis caused by Rickettsia conorii, first isolated in India in 1950 from the brown dog tick (Rhipicephalus sanguineus). Reported primarily from Maharashtra, Tamil Nadu, Karnataka, and Kerala.

Kangri Cancer / Kangri Ulcer *- Kashmir*

A thermally-induced squamous cell carcinoma of the skin, seen almost exclusively in the Kashmir Valley. Results from chronic use of the kangri, a traditional earthenware fire-pot encased in wicker-work, carried against the abdomen and inner thighs for warmth in winter. Prolonged use produces erythema ab igne, which may progress to carcinoma. Documented in Bolognia's Dermatology and multiple Indian case series dating back to 1879. Note: the condition takes its name from the object (the kangri pot) rather than the place directly, but its use is intrinsically tied to Kashmir, so it is conventionally classified as a toponym.

Coolie Itch *- India (tea plantations)*

A cutaneous condition caused by the mite Rhizoglyphus parasiticus, characterized by intense pruritus and sore feet. Documented among tea plantation workers in India (Andrews' Diseases of the Skin).

Malabar Itch *- Malabar Coast, Kerala*

An older name for tinea imbricata, a superficial fungal infection caused by Trichophyton concentricum, presenting as concentric rings of overlapping scale forming papulosquamous patches. Also known as Tokelau in the Pacific context.

Goa Acne *(Acne Mallorca / Acne Aestivalis) - Goa*

A seasonal, recurrent, monomorphic papular eruption on sun-exposed skin, considered a variant of polymorphic light eruption triggered by UVA exposure. First described as "acne Mallorca" after cases in Mallorca, Spain; a clinically similar presentation reported from Goa gave rise to the parallel name "Goa acne."

2. Genodermatoses and Syndromes

Haim-Munk Syndrome ("Cochin Jewish Syndrome") *- Cochin (Kochi), Kerala*

A rare autosomal recessive syndrome caused by mutations in the cathepsin C gene, closely related to Papillon - Lefèvre syndrome. Features include palmoplantar keratoderma, periodontitis, arachnodactyly, and acro-osteolysis. First described in 1965 in four siblings from a Jewish isolate originating in Cochin, giving the alternate name "Cochin Jewish syndrome."

3. Diagnostic and Cosmetic Stains

Rose Bengal Stain *- West Bengal*

A pink diagnostic stain used in eyedrops to identify damaged conjunctival and corneal cells. Named not for a disease origin but because the pink color of the stain was said to resemble the forehead dot (bindi) traditionally worn by women of West Bengal.

4. Surgical and Therapeutic Techniques

Jaipur Block *- Jaipur, Rajasthan*

A technique for managing postherpetic neuralgia, proposed by Bhargava et al., involving local subcutaneous infiltration of 2% xylocaine, 0.5% bupivacaine, and dexamethasone. A modified version substituting methylprednisolone was later proposed by Neerja Puri.

Jodhpur Technique *- Jodhpur, Rajasthan*

An autologous, non-cultured, non-trypsinized melanocyte and keratinocyte grafting technique used in vitiligo surgery, developed and refined by a group of dermatology surgeons in Jodhpur.

5. Descriptive and Occupational Terms

Indian Filing *- India (descriptive term)*

A histopathological pattern in which epithelial cells with atypical nuclei are arranged as single-file strands between collagen bundles, seen in metastatic carcinomas, certain leukemias, and melanoma. Included in dermatology toponym compilations, though its classification as a true geographic toponym versus a purely descriptive term remains debated in the literature.

Dhobi Itch (Dhobie Itch) *- India (etymological, from Hindi "dhobi" - washerman)*

A colloquial term for tinea cruris (groin ringworm) and related irritant contact dermatitis, historically attributed to contamination of laundered clothing handled by washermen, or to the harsh detergents/starches used in the process. Not a formal medical term, but in wide colloquial and older textbook use in South Asia.

Toponyms are a compressed form of medical history — each one a small archive of who first saw the disease, where, and under what circumstances. Reading dermatology through India's map doesn't just make the terminology easier to remember; it's a reminder of how much of the specialty's descriptive vocabulary has quietly been shaped by Indian clinicians, Indian patients, and Indian geography — long before "toponym" ever needed to be looked up in a dictionary.

Compiled from published toponym reviews including Ramesh H, Somashekar S. Toponyms in Dermatology. Indian J Dermatol 2022;67:279-282; Radhika SR, Shilpa K, Hongal AA, Revathi TN. "Toponym" conditions in dermatology. Indian J Dermatol Venereol Leprol 2022;88:123-127; and standard dermatology references (Andrews' Diseases of the Skin, Bolognia's Dermatology).

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CASE-PODIUM:
A CASE OF GRANULOMA INGUINALE MASQUERADING AS ESTHIOMENE.

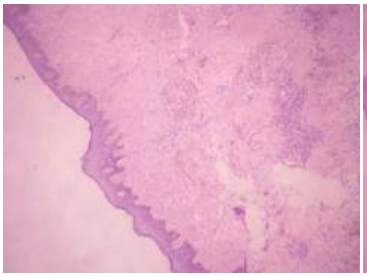
Dr. Sarada Bandyopadhyay,
RMO cum Clinical Tutor
Bankura Sammilani MCH

Genital elephantiasis in female is extremely rare.Recently a 26 year old young female,P1+0,3 month post partum was referred to us from G&O OPD with a non compressible swelling of bilateral labia majora with fissure and discharge from introitus(Figure-1,2).There was no palpable inguinal or femoral lymphadenopathy.She denied any symptom in partner or any history of other high risk sexual behaviour.

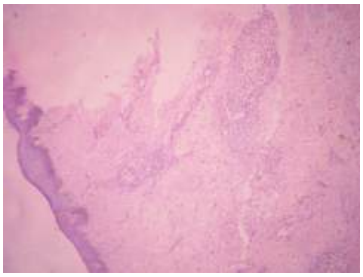
[fig 1]

[fig 2]

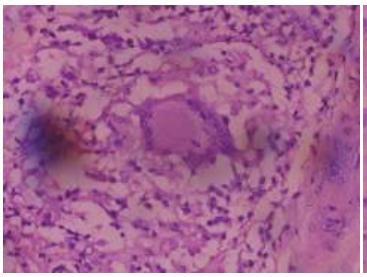
We treated the patient for vaginal discharge syndrome with NACO syndromic management kit and she improved after 2 weeks though the labial swelling persisted.Surgical excision was done by gynaecologist.But the swelling of labia majora recurred 2 months after same.Histopathology of the excised mass showed granulomatous inflammation with plasma cell infiltrate in clusters along with giant cells and lymphocytes(Figure-3,4,5,6).On examination,there was a non tender,non compressible bilateral swelling of labia majora and a large irregular ulcerative area involving whole of mucosal aspect of vulva.On rubbing the ulcer,bleeding started(Figure-7).We referred her to the Department of Microbiology for Gram Stain,Giemsa Stain,Ziehl Neelsen stain and True NAAT.Although Gram stain,Zn stain and True NAAT were negative,Giemsa Stain showed Large mononuclear cells containing safety pin like structures suggestive of Donovan Bodies of Klebsiella granulomatis,pointing to the case as Granuloma Inguinale.(Figure-8).We started with both Azithromycin and Cotrimoxazole because of her extensive lesion and to prevent further scarring and disfigurement,



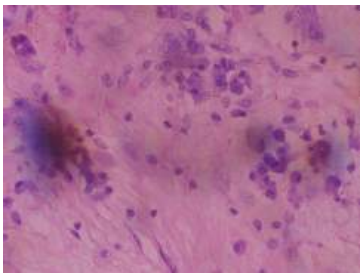
[fig 3]



[fig 4]

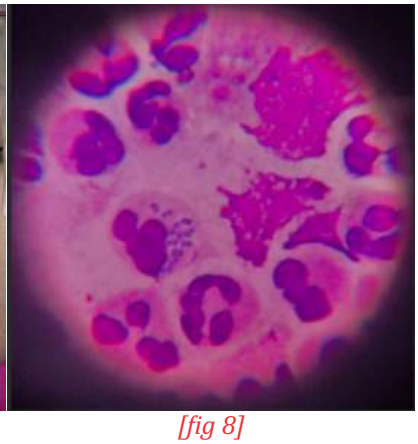


[fig 5]



[fig 6]

[fig 7]



[fig 8]

Esthiomene is a chronic destructive,hypertrophic inflammatory condition of the vulva classically associated with lymphatic obstruction and chronic infection or inflammation seen in lymphogranuloma venerum(LGV) and rarely in GI (Granuloma inguinale).

Granuloma inguinale is extremely less reported and presenting as esthiomene is even more rare.There is chronic granulomatous inflammation of genital and perigenital

mucosa typically producing painless beefy red ulcers going unnoticed.Chronic inflammation and lymphatic obstruction can eventually result in marked vulval edema,fibrosis and hypertrophy producing elephantiasis or esthiomene like presentation.This represents an unusual and underrecognised complications of long standing Donovanosis.

In established esthiomene,antimicrobial therapy treats the active infection but long standing fibrosis and lymphatic damage may persist and may require reconstructive surgery.The significance of this case lies in the unusual presentation of granuloma inguinale as esthiomene emphasizing that Donovanosis should be included on the differential diagnosis of chronic vulval elephantiasis particularly in endemic setting where filariasis is a commoner entity presenting as vulval elephantiasis.

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1. *Balakrishnan P, Vijayan S. Vulvar donovanosis – an unusual cause of genital ulcer in a female. World J Women's Child Health. 2023;2(2):83-85. doi:10.25259/WJWCH_29_2023.*
2. *Kaur M, Malik R, Datta K, Khera K. A rare case report of large bilateral vulval elephantiasis. Int J Reprod Contracept Obstet Gynecol. 2020;9(6):2527-2529. doi:10.18203/2320-1770.ijrcog20202367.*
3. *Singh MP, Saluja R. A rare presentation of elephantiasis involving vulvae in an Indian female. Indian J Dermatol Venereol Leprol. 2020;86(6):753. doi:10.4103/ijdvl.IJDVL_274_18. PMID:32525103.*
4. *Chakraborty M, Banu H, Chakraborty PP. Bilateral vulval filarial elephantiasis. BMJ Case Rep. 2018;2018:bcr2018224250. doi:10.1136/bcr-2018-224250.*

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IADVL SIG Dermatology Clinical Research: 16th August 2026 at Taj Vivanta, Kolkata, CME on Dermatology Clinical Research

IADVL organized a premier educational initiative focused entirely on Dermatology Clinical Research at Taj Vivanta, Kolkata, on August 16, 2026. Organized by the Indian Association of Dermatologists, Venereologists & Leprologists (IADVL) EC and the SIG Dermatology Clinical Research under the IADVL Academy, in association with the IADVL West Bengal Branch, this full-day event was designed to foster a robust dermatologist-scientist mindset.

The day's proceedings commenced with a traditional lamp lighting and an inauguration featuring a welcome address by Dr. Arghyaprasun Ghosh, President of IADVL WB, alongside opening remarks by Dr. Rajwinder Singh, Coordinator of SIG DCR.

The scientific program offered a deep dive into the mechanics of conducting and publishing high-quality medical research, with meticulously planned sessions that included:

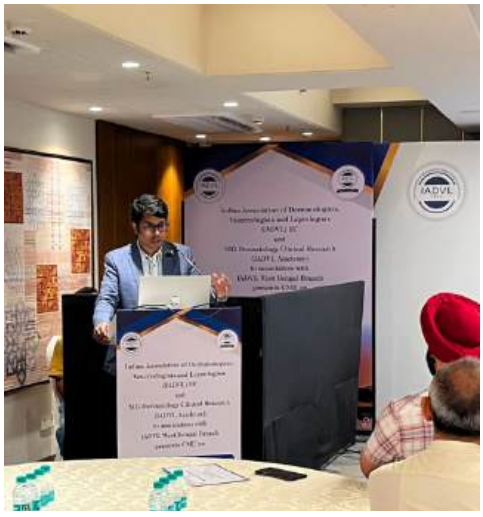
Fundamentals of Research: Insights on why research matters by Dr. Abhishek De, followed by guidance on framing FINER and PICO research questions and simplifying study designs by Dr. Rajwinder Singh.

Data & Literature Mastery: A practical look at reference management using Zotero with Dr. SK Shahriar Ahmed, basics of biostatistics by Dr. Rajwinder Singh, and an insightful talk on literature review covering PubMed, Google Scholar, and Cochrane by Dr. Indrashish Podder.

Ethics and Modern Tools: Comprehensive talks on sample size calculation by Dr. Abhijit Mukherjee, research ethics and IEC approval by Dr. Saumya Panda, and CTRI registration with Good Clinical Practice by Dr. Vivek Kr. Dey. Furthermore, Dr. Suparna Chatterjee explored AI as a research tool, while Dr. Pramit Ghosh tackled data analysis using statistical software.

Publication Strategies: Essential guidance on manuscript writing from abstract to full paper by Dr. Indrashis Podder, and navigating manuscript rejection, peer review, and predatory journals with Dr. Anupam Das.



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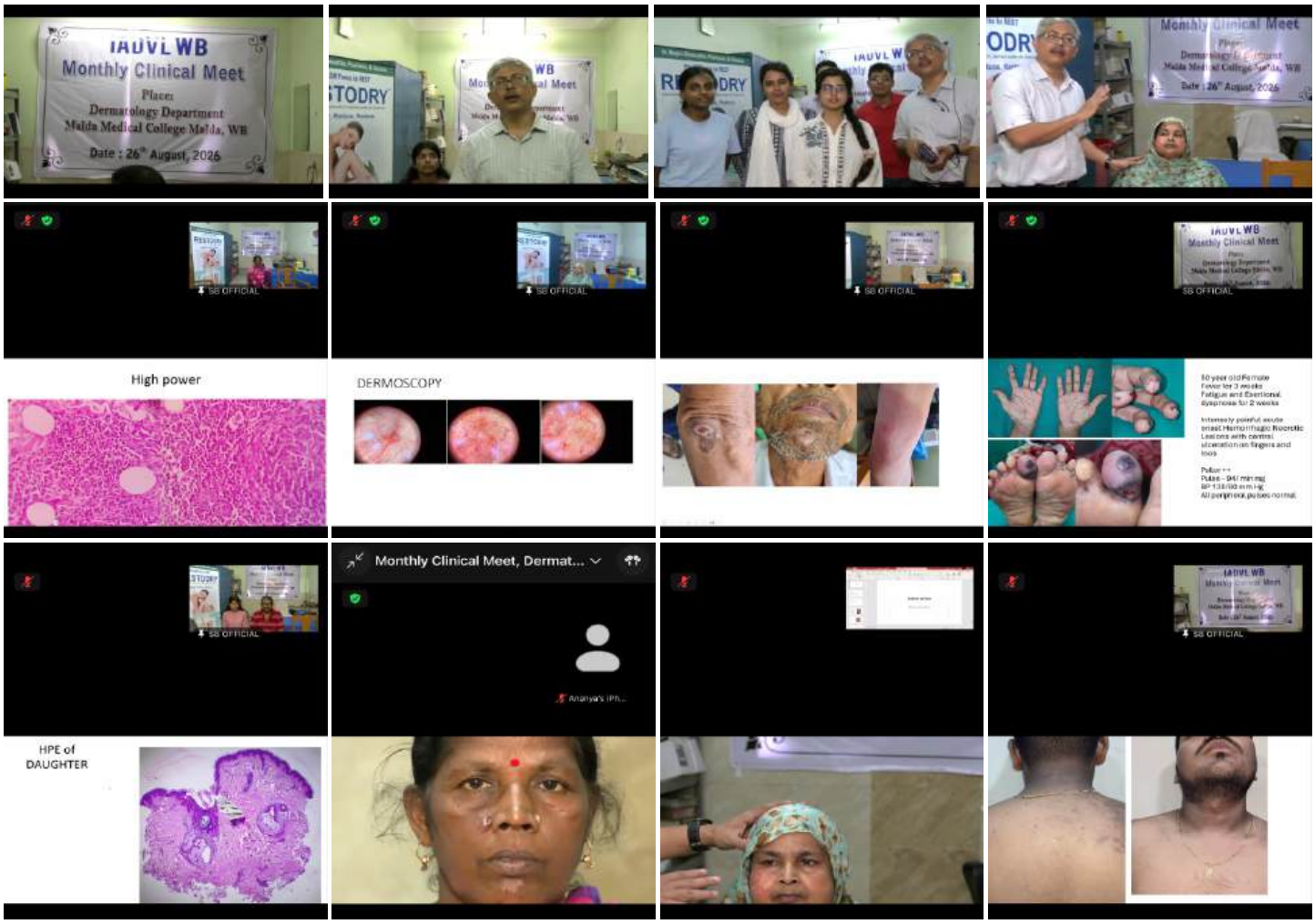
Monthly Clinical Meeting of IADVL WB on 28/08/2026 at Malda Medical College, and through virtual platform

On August 26, 2026, the Dermatology Department at Malda Medical College successfully hosted a comprehensive clinical meeting. Embracing a hybrid format, the session was conducted in both online and offline modes, allowing for wider participation and seamless engagement among attendees. The academic proceedings were carefully curated and held under the expert guidance of Dr. Nilendu Sarma, Head of the Dermatology Department.

This meeting provided an excellent platform for post-graduate trainees and practicing dermatologists to delve into the diagnostic intricacies and management of various rare and complex skin conditions. The diverse clinical docket featured in-depth discussions on the following cases:

- *Familial comedones without dyskeratosis with Dowling-Degos disease*
- *Kimura disease*
- *Chromoblastomycosis*
- *Primary cutaneous CD30-positive lymphoproliferative disorders*
- *Lymphomatoid papulosis*
- *Cutaneous ALCL*
- *Non-Langerhans cell histiocytosis of dendritic cell origin without significant systemic involvement*
- *Post-Kala-Azar Dermal Leishmaniasis (PKDL)*
- *Erythema elevatum diutinum*
- *Subacute bacterial endocarditis with secondary infection*
- *Klippel-Trenaunay syndrome*
- *Cartilage-hair hypoplasia*



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IADVL WB SOCIAL AWARENESS HEALTH CAMP

A skin health and awareness camp was organised on 30.8.26 at Rotary Ramthakur Briddhabas which presently has around 35 senior citizen residents. It was attended by Dr Sujata Sengupta, DrArijit Coondo, Dr Aditi Chakrabarti and Dr Aarti Sarda. There was a talk on geriatric skin care by Dr Aarti Sarda followed by examination for skin ailments by all four of us. Non ambulatory residents were examined at bedside. Medications were handed out as needed. A hamper containing coconut oil and an emollient was given to each resident.
Thankful to IADVL office staff Khageswas Das and Adirex pharma and Dr Reddys for providing gift hamper

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IADVL SIG Dermatology Clinical Research: 30th August 2026 at Hyatt Regency, Kolkata, CME on Recent Advances in Psoriasis

The Indian Association of Dermatologists, Venereologists & Leprologists (IADVL) EC and the SIG Psoriasis under the IADVL Academy, in association with the IADVL West Bengal Branch organized a premier educational initiative focused on Recent Advances in Psoriasis at the Hyatt Regency, Kolkata, on August 30, 2026.

The day's proceedings commenced with a traditional lamp lighting and an inauguration featuring a welcome address by Dr. Arghyaprasun Ghosh, President of IADVL WB, and an address by Hon. Secretary Dr. Somenath Sarkar, alongside opening remarks by Dr. Shekhar Neema, Coordinator of SIG Psoriasis.

The scientific program offered a deep dive into evolving therapeutic strategies, with meticulously planned sessions that included:

***Foundational & Systemic Management**: An evidence-based approach to choosing conventional therapy by Dr. Saumya Panda, followed by practical guidance on optimizing Methotrexate and Apremilast by Dr. Sanjay Ghosh. Dr. Sudip Kr. Ghosh mapped out the complex spectrum of comorbidities beyond the skin, while Dr. Somenath Sarkar delivered crucial updates on managing pediatric psoriasis.*

***Advanced Diagnostics & Biologics**: Comprehensive talks on the pathogenesis, diagnosis, and management of Psoriatic Arthritis by Dr. Shekhar Neema, alongside an evidence-based approach to selecting biologics by Dr. Sachin Verma. Furthermore, Dr. Abhishek De provided an in-depth exploration of IL-17 blockers in targeted dermatological care.*

***Dynamic Panel Discussions**: Theoretical insights were grounded by highly interactive, case-based panel discussions. Dr. Indrashis Podder moderated the first session with expert clinical inputs from Dr. Saumya Panda, Dr. Shekhar Neema, Dr. Sudip Kr. Ghosh, Dr. Partha Mukhopadhyay and Dr. Somenath Sarkar. The second panel, expertly guided by Dr. Aarti Sarda, featured robust discourse from Dr. Shekhar Neema, Dr. Abhishek De, Dr. Surajit Gorai and Dr. Sachin Verma.*

The event concluded with impactful key take-home messages delivered by State Coordinator Dr. Abhishek De, followed by a formal vote of thanks from Dr. Somenath Sarkar.

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DERMAGINATIONS: PAGING PASSION BEYOND PRACTICE

Dr. Nirjhar Mondal
Associate Professor
Rampurhat MCH

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Quiz Zone

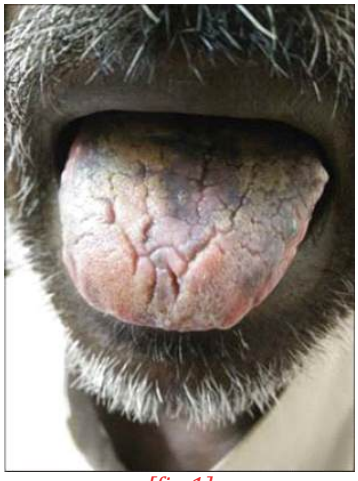
1) *Patient C presented with multiple erosions over his face and trunk and inability to eat due to pain and burning sensation in mouth ,since the last 1 month. The lesions developed as small blisters which easily ruptured and left expanding erosions. On examination of his oral mucosa, along with multiple eroded patches on the buccal mucosa, a characteristic appearance was seen on his tongue. Identify the eponymous clinical sign described by a famous Indian dermatologist. (figure 1)*

2) *Identify the clinical sign from the image provided (figure 2) and also mention the disease associated with it.*

3) *A female' Y' hailing from southern India presented with hyperpigmented keratotic papules over the back and sides of her neck since last 4 months which were otherwise asymptomatic. She was in the habit of using plenty of coconut oil to maintain her long hair. Identify this indigenously described disease entity by studying (figure 3).*

4) *A patient complained of throbbing pain over her right thumb since last 3 months which was growing in intensity gradually with exacerbation on exposure to cold. The nail over the right thumb had a queer appearance. Identify the nail abnormality from(figure 4) and the possible cause of the abnormality according to the vignette.*

5) *A patient presented with chief compliant of thickening and darkening of skin over bilateral palms and soles since last 4 months .He notified that he was also having rapid weightloss and difficulty swallowing food for the last 2 months. On examination, hyperkeratotic,hyperpigmented plaques were noted in a symmetrical distribution over his palms and soles and was associated with paronychia. Identify the condition..(figure 5)*



[fig 1]

[fig 2]

[fig 3]

[fig 4]

[fig 5]

The correct response given: Dr. Shatanik Bhattacharya for Dermawiz & Quiz

Thank You for your answer and happy reading

Kindly send your entry to iadvlwb@gmail.com with 'Skintellect Quiz' as subject.
The correct response of each month gets acknowledged in the next issue.
Send your entries now!
Good luck from Team Skintellect.

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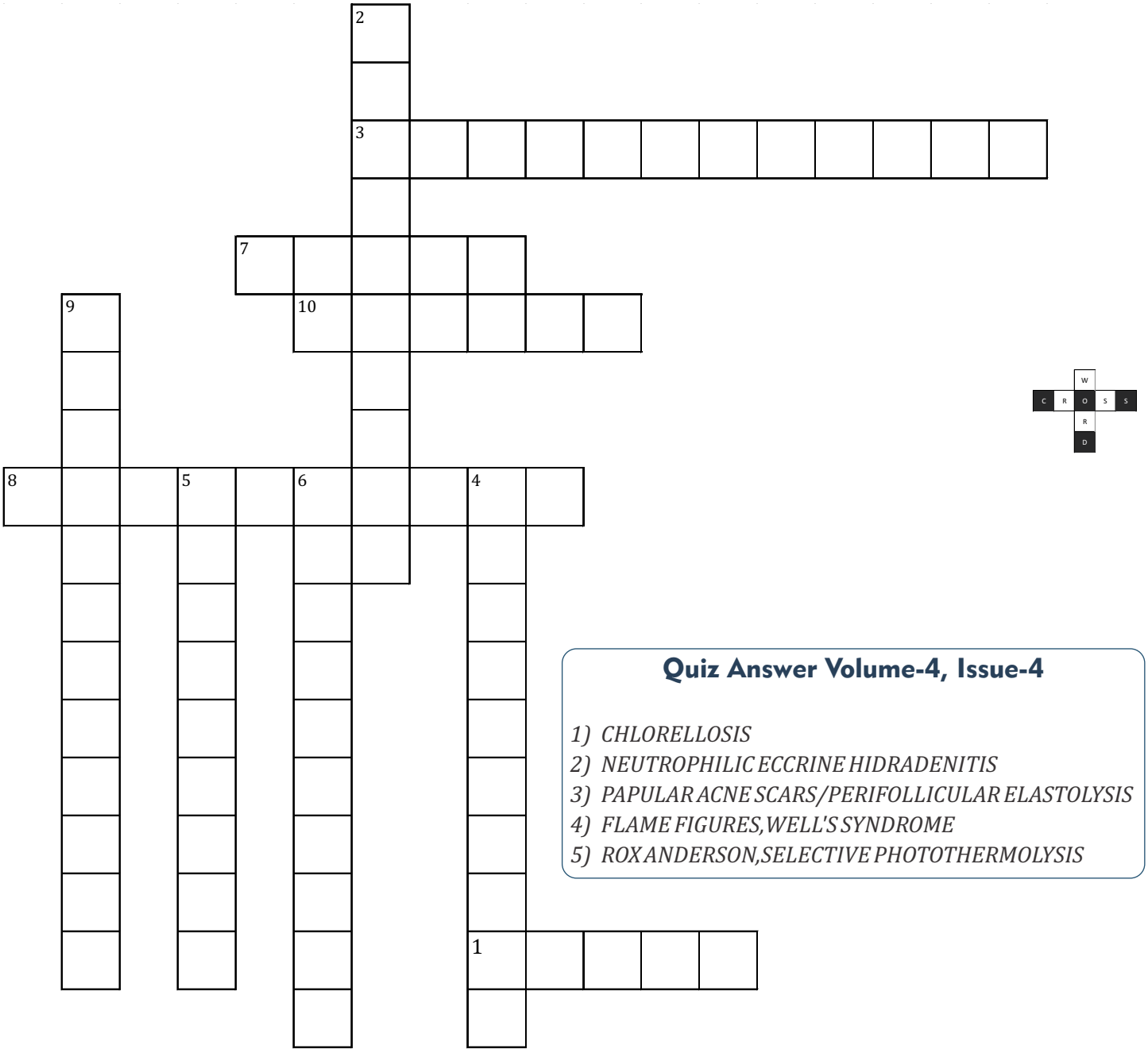
Brainstorm

Across

1. Gene defect in Pseudoxanthoma elasticum (5)
3. Neonatal FcRn antagonist – emerging agent in pemphigus (12)
7. —— sign: axillary freckling in NF-1 (5)
8. Tyrosine kinase inhibitor – newly emerging agent in systemic sclerosis (10)
10. Gene defect in Mal de Meleda (6)

Down

2. IL-36 receptor inhibitor approved for generalized pustular psoriasis (GPP) (10)
4. Fastest-acting IL-17 inhibitor in psoriasis (10)
5. Aryl hydrocarbon receptor agonist FDA-approved in chronic plaque psoriasis and atopic dermatitis (9)
6. BRAF V600 inhibitor FDA-approved in melanoma (10)
9. Newer drug FDA-approved for gonorrhea (12)



Quiz Answer Volume-4, Issue-4

1) *CHLORELLOSIS*
2) *NEUTROPHILIC ECCRINE HIDRADENITIS*
3) *PAPULAR ACNE SCARS/PERIFOLLICULAR ELASTOLYSIS*
4) *FLAME FIGURES, WELL'S SYNDROME*
5) *ROX ANDERSON, SELECTIVE PHOTOTHERMOLYSIS*

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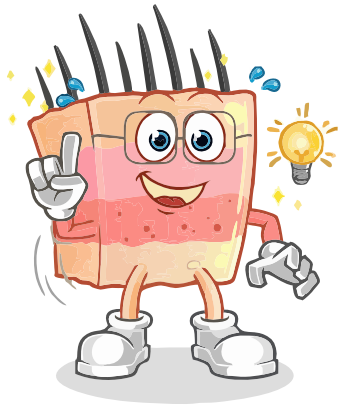
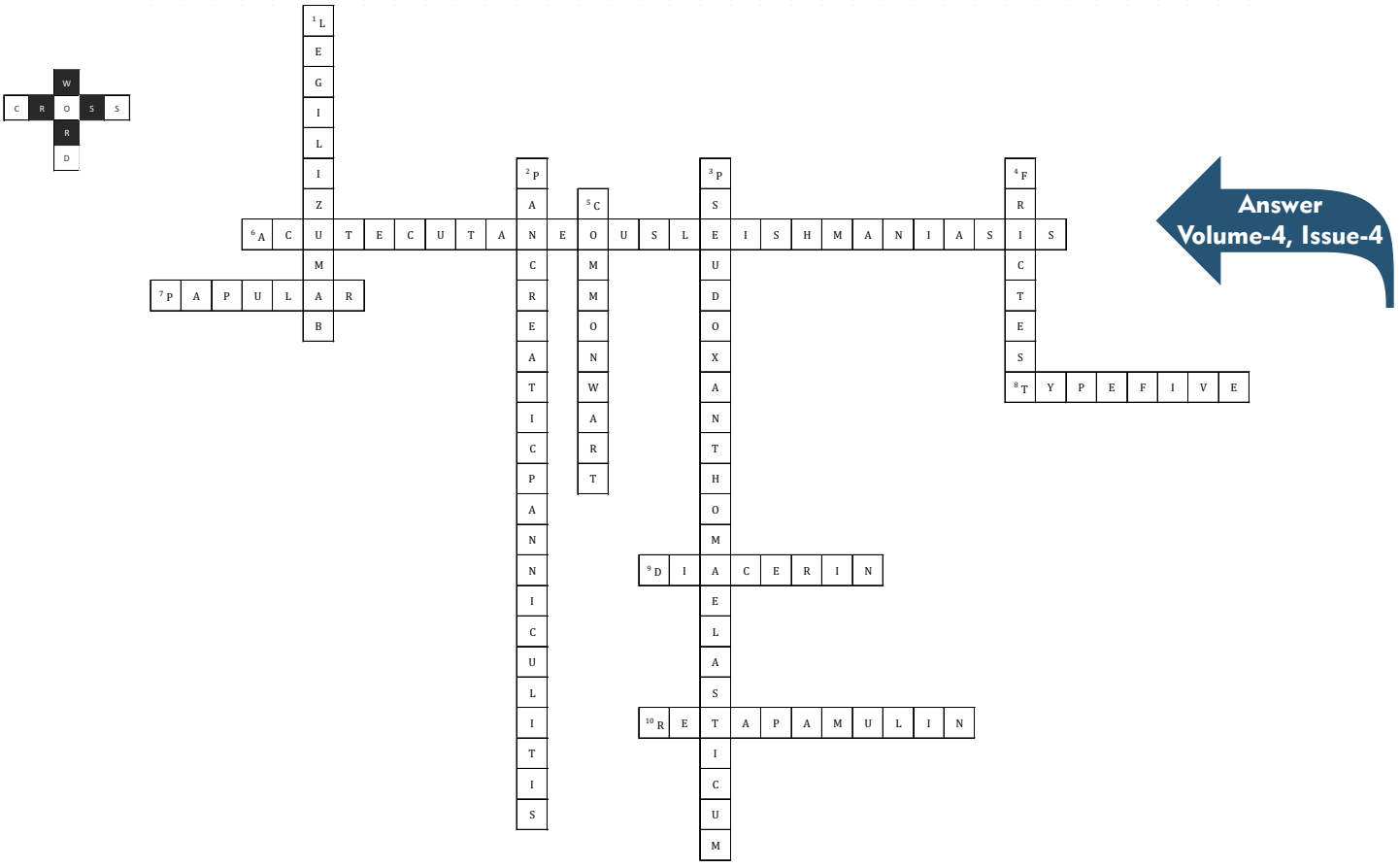


Dermwiz

Sunlight burns what should just tan,
My cells can't fix the broken strand.
Freckles early, eyes grow dry,
Cancers come before I'm old .
Repair genes fail, the damage stays,
I fear the touch of ordinary days.

Dermwiz Answer
Volume-4, Issue-4

Trichorrhexis nodosa



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

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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