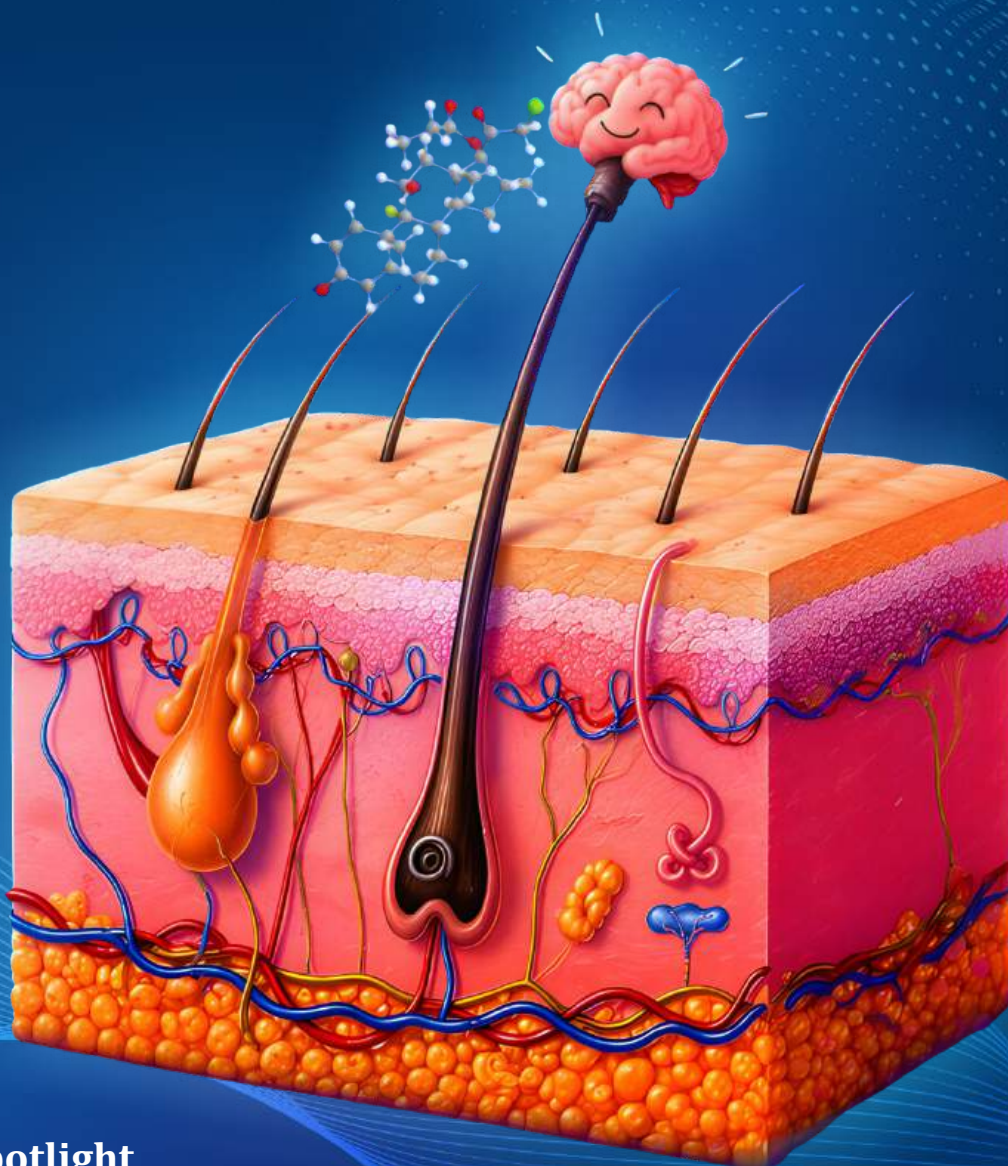




SKINTELLECT

The Official Newsletter of the IADVL West Bengal State Branch



Issue Spotlight

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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.

Volume 4, Issue 6, October 2026



SKINTELLECT

The Official Newsletter of the IADVL West Bengal State Branch



Volume 4 Number 06
October 2026

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Note from the President

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

I must compliment the editor Dr Ameli Sarkar and her team for meticulously preparing each issue of Skintellect not only on time but also with rich academic content.

We are in the midst of preparations for the Dermazone East and CUTICON WB 2026 to be held in the last week of November this year. The Organizing Committee under Dr Chinmay Kar, the Organizing Secretary and the Scientific Committee under Dr Nilay Kanti Das, the Scientific Chairperson and Dr Indrashis Podder, the Scientific Secretary and their teams are working round the clock to make the conference a grand success.

In continuation of our commitment to social responsibilities we were part of a health camp organized by Sanhati Club, Sodepur, Kolkata held on the 13th of September, 2026. Dr Supratim Saha, Dr Shoubhick Biswas and myself examined more than 100 patients and distributed essential medicines with the help of our office staff Mr. Diptanshu Paul and Mr. Subhashis Bose. Looking forward to organizing more such health camps in the near future with the active participation of our members.

We have a number of scientific programs lined up in the near future and hope they turn out to be great learning experience for all of us.

I wish our members and their families good health and a very happy and joyous festive season ahead.

With sincere regards

Long Live IADVL

Jai Hind



*Dr. Arghyaprasun Ghosh
President
IADVL WB*



Secretary's Scribes

It gives me immense pleasure to connect with all members of IADVL West Bengal through another issue of Skintellect, our official monthly web journal. Skintellect continues to serve as an important platform for sharing our academic activities, professional updates, achievements and initiatives, while keeping our fraternity connected and informed.

As part of our commitment towards community outreach and social responsibility, the IADVL West Bengal State Branch has recently conducted several dermatology camps to provide accessible dermatological care and create awareness about common skin diseases among the community. These initiatives reflect our belief that the role of a dermatologist extends beyond the hospital and clinic, and that our collective expertise can make a meaningful difference in society. We look forward to continuing and expanding such community-oriented activities in the coming months.



Our academic activities are also continuing with great enthusiasm. Through CMEs, webinars, SIG activities, academic meetings and various educational programmes, we remain committed to promoting continuous learning and professional development among our members. I sincerely appreciate the efforts of all our office bearers, academic coordinators, faculty members and participating delegates who continue to contribute to the academic growth of our state branch.

I am particularly pleased to invite all members of IADVL West Bengal to Dermazone East 2026, which is going to be held from 27th to 29th November 2026 at Biswa Bangla Convention Centre, Kolkata. This important academic gathering will provide an excellent opportunity for dermatologists from across the eastern region to come together, share knowledge and experience, discuss recent advances in dermatology and strengthen professional interactions. I warmly invite all our members to participate actively and make this conference a memorable and academically enriching event.

As we approach the festive season, I extend my heartfelt greetings and best wishes to all members of IADVL West Bengal and their families on the auspicious occasion of Durga Puja. May Maa Durga bless everyone with good health, happiness, peace and prosperity. Let this festive season bring renewed energy, harmony and togetherness to our IADVL family.

I look forward to your continued support and active participation in all the initiatives of IADVL West Bengal.

With warm regards,

Dr. Somenath Sarkar
Honorary Secretary
IADVL WB



Editors Desk

Dear Readers,

With the festive season coming in an atmosphere of celebration and togetherness, it is our pleasure to bring you the September edition of Skintellect.

Dr Manababrata Majumdar has shared his journey through the years in the field of dermatology.

Dr Dipra Biswas has highlighted the treatment modalities for keloids and hypertrophic scars.

Our Residents' Corner once again celebrates the spirit of inquiry among young dermatologists. Dr. Astha Gupta has bust several myths about eczema.

Dr Dhiman Tarafdar has presented a case of granulomatous pyoderma gangreosum in our case podium

And, as always, learning comes with a dash of fun in Skintellect. Our Quiz, Crossword, and Riddle await those who enjoy putting their dermatological knowledge and wit to the test. Dr Ayan Samanta sir has contributed a poem on everyone's favourite snack samosa.

An amazing health camp by IADVL was organised.

As we step into the festive season, may the days ahead be filled with light, laughter, togetherness, and renewed inspiration. May this edition of Skintellect not only inform and engage you, but also accompany you in the spirit of celebration.

Wishing all our readers a joyous, prosperous, and fulfilling festive season.

Warm regards,



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

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DERMATOLOGIST SPOTLIGHT: DR. MANABBRATA MAJUMDAR

1. *Sir, could you take us through your journey in dermatology—what initially drew you to the specialty, and which experiences along the way have shaped the dermatologist you are today?*

During my internship, I had the opportunity to work in different disciplines of medicine, including Paediatrics, Psychiatry and Dermatology. It was during this period that I decided to specialise in Dermatology and make it my profession.

During my postgraduate training, I had the privilege of learning under renowned teachers who gave me a strong foundation in Dermatology and taught me how to approach and manage different clinical cases.

During my entire service under the West Bengal Government, I was the only dermatologist in my department. This gave me the opportunity to encounter a wide variety of dermatological diseases and challenging cases. There were also occasions when I made an incorrect diagnosis, which was subsequently corrected with the help of colleagues from other institutions. These experiences taught me the importance of continuous learning, consultation and keeping an open mind.

2. *Even after years of experience, are there cases that still make you pause, question your first impression, or send you back to the books? What keeps you curious after all these years?*

Yes, certainly. Even after years of experience, there are cases where I still have to pause, rethink my diagnosis, consult books and discuss the case with colleagues.

While establishing my dermatological practice, I received valuable guidance and support from several senior dermatologists, including Late Dr. Barindranath Bhadra, Late Dr. Animesh Chatterjee, Late Dr. R. K. Panja, Late Dr. B. N. Halder and Dr. Nitin Mukherjee. Their guidance has been an important part of my journey.

3. *For a young dermatologist stepping out of residency, what should come first when starting clinical practice—building clinical confidence, finding the right practice setup, or developing a patient base?*

For me, the first priority was building a patient base, and that process is still continuing. I always made it a point to attend the hospital OPD and my chamber regularly and at the scheduled time.

I believe that being available to patients consistently and sincerely is very important in building trust and, eventually, a practice.

4. *India's dermatophytosis landscape has changed dramatically over the years. What has been the most challenging aspect of managing chronic or recurrent tinea, and what has this experience taught you about the way we practise dermatology?*

Nowadays, the treatment of dermatophytosis has become more difficult because of the emergence of resistant varieties. Patients often require prolonged and continuous treatment.

This has taught us that dermatophytosis cannot always be approached as a simple, short-term infection. Proper diagnosis, appropriate treatment and ensuring adequate follow-up are increasingly important.

5. *If you had just one minute to bust one dermatological myth forever, which myth would you choose—and what would you want the public to understand instead?*

I would like to dispel the misconception that all skin diseases are infectious.

Many skin diseases are not infectious at all, and many of them are completely treatable. People should therefore avoid unnecessary fear, stigma and social isolation simply because someone has a visible skin condition.





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6. *Beyond the clinic and the white coat, what brings out a different side of your personality? Is there an interest, hobby, or passion that your patients—or even your colleagues—might be surprised to know about?*

Obviously, I enjoy spending time with my hobbies, particularly watching movies. It gives me an opportunity to relax, take a break from the routine of clinical practice and enjoy a completely different world outside medicine.

7. *When you look back at your journey so far, which moments or achievements give you the greatest sense of fulfilment—not just as a dermatologist, but as a person?*

For me, the greatest satisfaction comes from treating my patients sincerely and encouraging them throughout their treatment.

When patients improve and are satisfied with the treatment they have received, their satisfaction becomes my satisfaction. That, ultimately, is what gives me the greatest sense of fulfilment as a dermatologist.



DERMBUZZ : BEYOND THE SCAR:

AN UPDATE IN THE MANAGEMENT OF HYPERTROPHIC SCARS AND KELOIDS

Introduction: Hypertrophic scars (HTS) and keloids represent aberrant responses to cutaneous injury, characterised by excessive extracellular matrix deposition, persistent fibroblast/myofibroblast activity and dysregulated wound healing. Although both are raised and often symptomatic, their clinical behaviour differs. HTS generally remain confined to the boundaries of the original wound and may undergo gradual spontaneous regression, whereas keloids extend beyond the site of injury and demonstrate a greater propensity for persistence and recurrence. Beyond their cosmetic impact, pruritus, pain, restricted movement and substantial psychosocial morbidity make pathological scars an important therapeutic challenge. Despite numerous available interventions, no single modality consistently provides complete and permanent resolution.

Prevention: treatment begins before the scar becomes pathological

Prevention is particularly important in individuals with a previous history of keloid formation or those undergoing procedures at high-risk anatomical sites. Meticulous surgical technique, minimising wound tension, appropriate wound approximation and early control of inflammation are fundamental. Silicone gel or silicone sheets and pressure therapy remain established non-invasive approaches, particularly during the early remodelling phase. Pressure therapy can reduce scar thickness, erythema and hardness, although adherence frequently limits its effectiveness. [1,2]

Patients with a strong personal history of keloids should be counselled regarding the risk associated with elective procedures. Early intervention when a scar begins to become symptomatic or elevated may be more effective than treating a mature lesion. Recent practical approaches therefore emphasise early recognition and combination therapy rather than waiting for complete scar maturation. [2]

Intralesional corticosteroids: still the backbone

Intralesional triamcinolone acetonide (IL-TAC) remains one of the most widely used treatments for established HTS and keloids because of its accessibility, familiarity and anti-inflammatory and antifibrotic effects. It suppresses fibroblast proliferation, collagen synthesis and inflammatory mediators. However, monotherapy is limited by incomplete response and recurrence, while adverse effects include pain, dermal atrophy, telangiectasia and hypo- or hyperpigmentation. [1,3]

Consequently, contemporary practice increasingly uses IL-TAC as part of a combination rather than as isolated therapy. The addition of 5-fluorouracil (5-FU), a pyrimidine analogue that inhibits fibroblast proliferation, has demonstrated greater efficacy in several comparative studies than either agent alone, although ulceration and post-inflammatory pigmentary alterations may occur. [3,4]

Beyond steroids: expanding the intralesional armamentarium

Intralesional 5-FU, either alone or combined with corticosteroids, has emerged as one of the better-studied alternatives. Other investigated agents include bleomycin, verapamil, botulinum toxin A and platelet-rich plasma. Evidence for verapamil is mixed; although its antifibrotic effects are biologically attractive, clinical studies have generally not demonstrated consistent superiority over corticosteroids. [3,4]

Bleomycin tattooing or injection can produce substantial flattening but is associated with pain, ulceration and pigmentary changes. Its role may therefore be considered in selected, treatment-resistant lesions rather than as routine first-line therapy. [3]

Botulinum toxin A represents a particularly interesting development. By reducing muscle activity and mechanical tension, and potentially modulating fibroblast behaviour, it may influence both scar formation and symptoms. Recent clinical evidence suggests benefit in selected keloids and HTS, particularly for pain and scar elevation; however, optimal dosing, injection schedules and its precise position in treatment algorithms require further clarification. [3,5]

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Deben Mahata Govt. MCH,
Purulia





Cryotherapy: from surface freezing to intralesional treatment

Cryotherapy remains useful for relatively small keloids, particularly when combined with intralesional corticosteroids. Conventional spray or contact cryotherapy induces vascular injury and tissue necrosis, but prolonged healing and post-inflammatory hypopigmentation can limit its use, particularly in darker skin phototypes.

Intralesional cryotherapy, in which the probe is introduced directly into the lesion, has emerged as an alternative that can achieve deeper and more controlled destruction while potentially reducing epidermal damage. Evidence suggests greater efficacy than conventional spray cryotherapy, although treatment-related pain, blistering and pigmentary alteration remain considerations. [2,3]

Lasers: remodelling rather than simple ablation

The role of lasers has evolved considerably. Pulsed-dye laser (PDL) primarily targets scar vascularity and may reduce erythema, pruritus and activity, whereas fractional ablative lasers, particularly fractional CO₂ lasers, create microscopic treatment zones that facilitate collagen remodelling and can enhance transdermal delivery of topical or intralesional agents.

Fractional laser-assisted drug delivery has therefore become an attractive strategy, allowing corticosteroids or 5-FU to penetrate the scar more effectively. Rather than viewing laser therapy as a stand-alone treatment, current evidence supports its use as an adjunct within multimodal scar management. [3,6]

Surgery: excision is not the endpoint

Simple surgical excision of a keloid should rarely be regarded as definitive treatment because recurrence rates can be substantial. The central principle is therefore excision plus adjuvant therapy. Options include postoperative corticosteroid injections, pressure therapy, silicone, cryotherapy and, in selected cases, radiotherapy.

Radiotherapy following surgical excision can substantially reduce recurrence in appropriately selected patients, particularly for large or recurrent keloids. However, concerns regarding radiation exposure, wound healing, pigmentation and theoretical carcinogenic risk necessitate careful patient selection and appropriate counselling. [2,7]

Emerging therapies: targeting the biology of the scar

Increasing understanding of keloid biology has shifted research towards molecularly targeted treatment. Aberrant TGF- β signalling, mechanotransduction, inflammatory pathways and fibroblast activation are potential therapeutic targets. Agents directed against these pathways remain largely investigational.

An especially interesting development is the exploration of Dupilumab, reflecting the possible contribution of type 2 inflammatory pathways to keloid biology. Early reports and systematic reviews suggest potential clinical benefit in selected patients, but available evidence remains limited and consists predominantly of small studies and case reports. Dupilumab should therefore currently be considered an investigational rather than established treatment. [8,9]

Other emerging approaches include novel molecular inhibitors, anti-fibrotic agents, regenerative therapies and strategies targeting mechanical signalling. Their future role will depend on well-designed randomised trials demonstrating durable efficacy and acceptable safety.

A practical contemporary approach

Management should be individualised according to scar type, size, site, duration, symptoms, skin phototype, previous treatment and recurrence risk. Small, early and symptomatic lesions may be managed with IL-TAC, with consideration of 5-FU combination therapy. Cryotherapy, laser-assisted treatment or other intralesional modalities can be considered for resistant lesions. Large, mature or recurrent keloids may require surgical excision followed by an appropriate adjuvant modality.



The emerging paradigm is therefore not “one scar, one treatment” but multimodal, stage-specific and recurrence-conscious management. Prevention, early intervention and long-term follow-up are as important as flattening the lesion itself.

Conclusion

The management of keloids and hypertrophic scars has progressed from relatively simple steroid injections and surgical excision towards individualized multimodal treatment. IL-TAC remains an important therapeutic foundation, while combination regimens incorporating 5-FU, cryotherapy and laser-based approaches have expanded treatment options. Botulinum toxin and biologic therapies such as dupilumab represent promising developments, although stronger evidence is needed. Ultimately, the goal extends beyond flattening a scar—to controlling symptoms, restoring function, minimising recurrence and improving the patient's quality of life.

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RESIDENT'S CORNER: FACTS AND MYTHS ABOUT ECZEMA/ SEPARATING THE FACTS FROM FICTION- SCRATCHING BEYOND THE SURFACE IN ECZEMA

"My skin would become a relentless itchy tormentor that thrived on stress" - this quote by a patient effectively summarizes the impact of eczema on a patient.

The term 'ECZEMA' was Coined in 543 AD by Aëtius Amidenus, a Greek word ekzein, meaning "to boil froth" or "to effervesce".

It is a clinical and histological pattern of inflammation of the skin seen in a variety of dermatoses with widely different etiologies.

Clinically, patients complain of itching and soreness of variable intensity, excoriation, exudation, fissuring, hyperkeratosis, lichenification, papulation, scaling and vesiculation. The terms 'dermatitis' and 'eczema' are synonymous, although some authors still use the term 'dermatitis' to include all types of cutaneous inflammation, so that all eczema is dermatitis, but not all dermatitis is eczema

Dr ASTHA GUPTA

*1st year dermatology resident
College of Medicine & JNM KALYANI*



Stages of Eczema –

Acute- Presents as red, edematous plaques accompanied by small, grouped vesicles.

Subacute -Appears as erythematous plaques that display scaling or crusting.

Chronic-Characterized by dry scales and lichenification, which includes triad of hyperpigmentation, accentuated skin markings and thickening of skin.

Causes and types of Eczema-

Eczema can be classified according to the cause as: exogenous and endogenous eczema.

Exogenous eczema develops due to external factors including irritant, allergic contact, photoallergic, airborne contact dermatitis, polymorphic light eruption, infective, dermatophytide, post-traumatic, and pityriasis alba.

Endogenous eczema occurs mainly due to internal or constitutional factors, includes atopic, seborrheic, asteatotic, discoid, eyelid, discoid, lichenoid, chronic dermatosis, pityriasis alba, hand eczema, venous eczema, juvenile plantar dermatosis, drug eruptions, lichen simplex chronicus, and prurigo nodularis.

Busting the Eczema Myth: Uncovering the Facts and Finding relief:

MYTH 1) Eczema Is Contagious!

FACT- It's not! You cannot 'catch' eczema by touching someone else's rash. The skin may appear red, scaly and oozing, which is a sign of inflammation, not a contagious infection.

MYTH 2) Eczema is always caused due to allergen

FACT - The exact causes of eczema are unknown. It's often associated with allergies, but is rarely caused by allergies alone. A recent model of Eczema in pathogenesis is the complex interplay between genetic predisposition, environmental factors and inflammatory response. This is clearly demonstrated by twin studies, which have shown a high concordance rate in monozygotic twins (0.77%), as compared to dizygotic twins (0.15%).



MYTH 3): Eczema is a sign of poor hygiene

FACT: Eczema has nothing to do with poor hygiene. In fact, it can be made worse by frequent hand-washing, or through the use of soap that dries out the skin. Instead, use soap-free, hypoallergenic cleansers and body washes that are free from lanolin, parabens and fragrances. These will help soothe skin and restore moisture, without irritating dry, itchy skin.

MYTH 4): If you have eczema, you'll develop asthma and hay fever

FACT: Eczema has been linked to asthma and hay fever. Children with a family history of asthma or hay fever are at an increased risk of developing eczema. Research shows that up to 40 per cent of infants with eczema go on to develop asthma and/or hay fever. However, not all people with eczema develop asthma or hay fever, and not all people with asthma or hay fever develop eczema.

MYTH 5): Family history of eczema means your child will get it too.

FACT: A family history of eczema does increase the likelihood of children developing eczema. If both parents have eczema, there is an 80 per cent chance that their children will also develop it. However, family history does not automatically mean your child will have the condition as well.

MYTH 6) Only Children Get Eczema

FACT- Not quite! Eczema (atopic dermatitis) can develop at any age. Early onset Most cases begin in childhood—45% within 6 months, 60% within 1 year, and 85% before age 5.

Late-onset: Can begin after puberty and is more common in women. Elderly-onset: A distinct subset can begin after age 60.

MYTH 7) Swimming Is a No-Go if You Have Eczema.

FACT -There's zero evidence that taking a dip in chlorinated pool is bad for atopic dermatitis. In fact, some people with eczema even take diluted bleach baths to aid in soothing their skin and preventing infections.

Bleach baths decrease staphylococcal as well as Methicillin-resistant *Staphylococcus aureus* colonization and decrease disease's severity. This involves soaking the body neck down in a tub filled with water (about 150 L) in which half a cup of 6% household bleach has been added. In Indian scenario, one teaspoonful (around 5 mL) of bleach can be added to a bucket of around 15 L of water.

MYTH 8) People with eczema should not bath regularly.

FACT: How often you bath, isn't as important as using Luke warm (rather than hot) water and avoiding fragranced soaps, bubble baths and other potential irritants.

Immediately after bath, pat dry with cotton towel and apply moisturizing cream as recommended in 3–5 min.

MYTH 9) Eczema doesn't need treatment, because you will just grow out of it.

FACT: It needs treatment, to break the itch - scratch cycle. The itch-scratch cycle is a self-perpetuating loop where scratching temporarily relieves an itch by blocking nerve signals, but physically damages the epidermal barrier provoking inflammation and nerve sensitization leading to release of cytokines ultimately intensifying itch -scratch loop



which can lead to abrasion and secondary infection.

MYTH 10) Eczema Can Be Cured

FACT: Maybe one day there will be a cure for eczema, but we aren't there yet. There are many effective treatments that help manage its symptoms, but eczema is a chronic relapsing condition. The therapeutic armamentarium ranges from liberal use of emollients, topical corticosteroids, topical calcineurin inhibitors, systemic immunosuppressive agents and phototherapy.

MYTH 11) Home remedies can cure eczema.

FACT: There is no such evidence. At best, home remedies like coconut oil can moisturize the skin and reduce itching or swelling.

Many patients get on a dermatologist's last nerve when they visit outpatient department, applying undiluted essential oils like pure tea tree oil or lavender oil, using undiluted apple cider vinegar, citrus juices, heated neem leaves, turmeric, raw garlic and commercial botanical lotions with hidden fragrances, resulting in irritant contact dermatitis.

MYTH 12) Certain food can cause eczema.

FACT: Unfortunately, this myth is also not true. However, if there are any particular foods triggering your eczema try avoiding those foods. Patients usually doubt the consumption of milk and milk products, eggs, seafood, shellfish, soy, peanuts, and wheat. Rowlands et al in their study described that out of the 58 double-blind placebo-controlled food challenges, only 1 had eczematous food reaction. Dietary elimination is not recommended routinely as there is no much evidence that it helps in improving atopic dermatitis. Elimination of egg or cow's milk in the diet has not shown any benefit based on Cochrane systematic review on randomized controlled trials and hence do not support the concept of dietary elimination.

To conclude,

"Managing eczema is not merely about suppressing flares, but sustaining a resilient skin barrier every day"

CASE-PODIUM:

GRANULOMATOUS PYODERMA GANGRENOSUM IN A 16-YEAR-OLD GIRL

Pyoderma gangrenosum is a neutrophilic dermatosis with varied clinical presentations.^[1] Granulomatous variants are uncommon and may mimic infectious granulomatous disorders, creating a diagnostic challenge.^[2]

*A 16-year-old female presented with a **non-healing ulcer over the right leg for 6 months**. The lesion initially began as a red, elevated solid lesion over the shin, associated with moderate pain and mild pruritus. It gradually increased in size with ulceration and oozing. Two similar lesions at other sites had healed with scarring. There was no history of trauma or surgery at the site or bowel abnormalities. She had received multiple antibiotics, including anti-tubercular therapy, with slight improvement.*

*Cutaneous examination revealed an **irregular, coalescing plaque measuring 12 × 8 cm** over the anterior lower right leg, with multiple erosions, haemorrhagic crusting and yellowish necrotic slough. The lesion had a well-defined inflamed edge with perilesional erythema and oedema. Mild induration and minimal tenderness were present. There was no active discharge or bleeding, and the lesion was not fixed to underlying structures. A hypertrophic scar was noted over the left forearm.*

*Differentials included **atypical mycobacterial infection, lupus vulgaris, actinomycetoma and pyoderma gangrenosum**. Ziehl-Neelsen stain showed no AFB. Histopathology from the centre of erosion revealed an ulcerated epidermis with dense mixed dermal inflammation and prominent neutrophils. Biopsy from the margin showed regular acanthosis, a dense mixed inflammatory infiltrate with epithelioid cell granulomas and Langhans giant cells, along with lobular panniculitis.*

*In view of the clinical course, histopathological findings and microbiological evaluation, a provisional diagnosis of **granulomatous pyoderma gangrenosum with secondary bacterial infection** was made. The patient was started on doxycycline and prednisolone, following which gradual improvement was noted.*

Superficial granulomatous pyoderma is a rare variant characterized by a slow progressive ulcer^[3], granulomatous inflammation and generally good response to corticosteroids^[4].

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Fig. 1:
Initial clinical picture



Fig. 2:
After 3 weeks of treatment

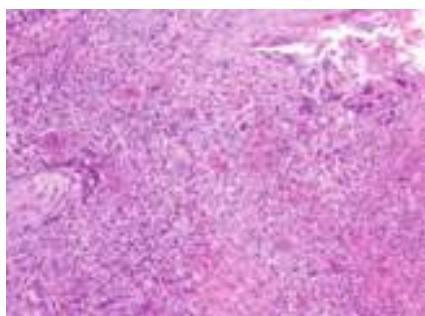


Fig. 3:
Dense inflammatory infiltrate
predominantly neutrophils



IADVL WB SOCIAL AWARENESS HEALTH CAMP

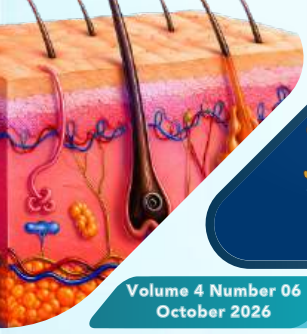
Community Skin Health Camp at Sodepur

A community skin health camp was successfully organized on 13th September at Sanhati Club, Sodepur, providing dermatological consultation and care to 103 patients.

The camp was conducted with the active participation of Dr. Supratim Saha, Dr. Shoubhik Biswas, and Dr. Arghyaprasun Ghosh, who provided comprehensive dermatological evaluation and guidance to the attendees.

The initiative reflects the continued commitment towards extending quality dermatological care beyond hospital settings and promoting awareness of skin health within the community.





DERMAGINATIONS: PAGING PASSION BEYOND PRACTICE

Dr. Ayan Samanta
Assistant Professor
RG Kar MCH

সিঙ্গাড়া-সামোসার সমস্যা

চায়ের সঙ্গে টা বললে আপনার মাথায় কি আসে বলুনতো? বিষয়টা দিনভাগের কোন সময়ের চা তার উপর অনেকটাই নির্ভর করে যদিও, তবে বিকেলের চায়ের সবপ্রিয় সঙ্গী কিন্তু সিঙ্গাড়াই। রক্তচাপ, শর্করা মায় স্নেহের সাধ্য কি এই রসনাবিলাসকে অতিক্রম করে? সকল অবক্ষয়ের মতো সিঙ্গাড়ার জৌলুসও অন্তিমিত। যদি বলি বাঙালী ভুলে গেছে এই পদের নিজস্ব সংস্করণ টি বানাতো। আমরা অনন্যোপায়, ভারতজুড়ে যে সামোসা পাওয়া যায় হয় সেটাই খাই নয় কিংকর্তব্যবিমূঢ় হলুইকরের বানানো না সিঙ্গাড়া না সামোসা গোছের স্বাদহীন ক্যালরি মন্ড টি খাই। সামোসা আর সিঙ্গাড়া আবার আলাদা নাকি এই কূট প্রশ্নটি মাথায় এলে তাকে ধরাশায়ী করুন। আগামী কয়েকটা বাক্যে আপনার সংশয় দূর করি। আসুন।

Wiki এবং অর্বাচীন ব্লগসমূহ ঘাঁটলে যা যা তথ্য পাবেন তাতে আপনার বন্ধমূল ধারণা হবে আসলে এই খাবার বহিরাগত। পাখি পড়ার মতো সঙ্কলে এক কথা বলে যাবে যেটা, অল্প কথায় বলি। মধ্যপ্রাচ্যে বা ইরানে (পারস্যে) প্রায় হাজার বছর আগে ত্রিকোণাকার একটি জনপ্রিয় জলখাবারের হৃদিশ পাওয়া যাচ্ছে যার নাম হল সামোসা যার ভেতরে মাংসের কিমা আর বিভিন্ন রকমের বাদাম কিসমিস দেওয়া পুর আর আবরণে অগ্নিপঙ্ক (সেকা বা baked) ময়দার খাস্তা আস্তরণ। সুলতানি আমলেই হিন্দুকুশ পেরিয়ে সুজলাং সুফলাং ভূমিতে আগমন আর সকলের (



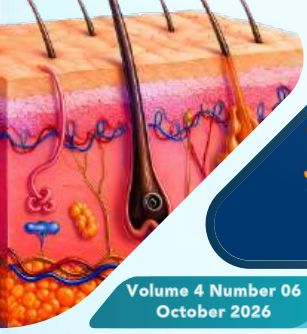
মানে যাদের টাঁকে পয়সা আছে) মন জয় করে নেওয়া। সামোসা উচ্চারণ ভেদে কোথাও হলো 'সামোসা' কোথাও হল 'সমুচা'। এই সমুচা কিন্তু প্রায় অবিকৃত প্রণালীতে বাংলাদেশে আজও এই নামেই পাওয়া যায় যদিও মাংস বর্জিত আলুর পুরের সামোসাকে ও তারা এই আদুরে নামেই ডেকে থাকে। আমাদের খিদিরপুর বাজারেও বিকেলের দিকে এই চ্যাট্টা মাংসের সামোসা রাজ ই ভাজে আর ঈদের সময় তো এটা delicacy। যাইহোক এই অবদি আম culinary রঙ্গে লেখে আমার খসরু, ইবন বতুতা-বতুতা মিশিয়ে টিশিয়ে।

এবারে যাব আমাদের দেশে সামোসার কি কি ভেরিয়েন্ট পাচ্ছি সেগুলো দেখে আমাদের প্রিয় সিঙ্গাড়ায় ফিরবো শেষে। পাঞ্জাবী সামোসা পাঞ্জাবীদের মতোই তাগড়াই। বড়, পুরু, নিষ্কলুষ, বাদামি খোল যেটা আবার আলুনি (উভয় অর্থে: বিশ্বাদ এবং লবণহীন)। ভেতরে কালচে রংয়ের পুর যাতে আলু কে মোটামুটি যতটা মশলা দেওয়া সম্ভব ততটাই মশলা, কিছু কড়াইশুটি, প্রভূত ধনেপাতা দিয়ে কর্দমপ্রায় মাখামাখা করে পাক করে। বলবন্ত, আজাদ হিন্দ, গুপ্তা প্রমুখ পাঞ্জাবি বাঘেদের পাল্লায় পড়ে বাংলার সিঙ্গাড়ার অবস্থা হয়েছে ওই ছেড়ে দে মা কেঁদে বাঁচি। সমগ্র উত্তর ভারত জুড়ে এই পাঞ্জাবী সামোসার সমস্যা। যে সমুচা বা সামোসার কথা বললাম তা খানিকটা জ্যামিতিক পরিবর্তনে ধরা পড়ে হায়দ্রাবাদের লুখমি তো। আকারে ছোট চৌকোনা (square) পুরু খোলের লুখমির উদরেও মাংসের পুর। খুব কাছাকাছি জিনিস হলো চামুসা বা চা (chamuca) যেটা গোয়াল পাওয়া যায়। কিন্তু অদ্ভুত ব্যাপার হলো এই হিন্দ-পর্্তুগিজ ঘরানার জলখাবার আজ খোদ লিসবনের রাস্তাতেও বিক্রি হয় ওই নামেই। কলোনিয়াল উত্তরাধিকার সূত্রে অঙ্গোলা বা মোজাম্বিকেও পাওয়া যায়, খাওয়া হয়, সেরকমই পড়লাম। চলে যাই দক্ষিণাচ্যে, সেখানে পাওয়া যাচ্ছে সামুসা। অঞ্চল বিশেষে নামের বা উচ্চারণের পরিবর্তন শুধু হচ্ছে তাই নয় পদ্ধতিও কিছু কিছু ভাবে পরিবর্তিত হয়ে যাচ্ছে। সামসা হবে ছোট যারে কয় বাইট সাইজ সূক্ষ্ম পরতের মুচমুচে খোল। পুরে থাকছে না আলু না মাংস। শুধু পেঁয়াজ আর আঞ্চলিক প্রতিনিধি হিসেবে থাকছে কারি পাতা।

এইবারে ফিরে আসি সিঙ্গাড়ায়। সামোসার সাথে পার্থক্য গুলো একে একে বলি। প্রথম হলো, আবরণ। পুরু নয় আবার সামসার মত পাতলাও নয়। সামোসা ঘিয়ে ভাজে এবং সেই ভাজা



দেখেছেন? ঠান্ডা বা কবোষ ঘিয়ে সামোসা গুলি ছেড়ে দেওয়া হয় যেগুলি তলায় সঁধিয়ে যায়। তেল ঘি খায়। ধীরে ধীরে ভাজা হলে উপরে উঠে আসে। এতে মজবুত খোল হয় শক্ত, নিটোল ও মসৃণ। উত্তর ভারতীয়রা দেখবেন বলে সামোসা তল রহি হয়। সিঙ্গাড়ার খোল না বলে খোসা বলা ভালো, মুচমুচে খাস্তা হবে কিন্তু পাতলা হবে এবং আজকাল যেটাকে crispy বলে সেটা নয়। হবে নুনযুক্ত স্বাদু ও ভঙ্গুর। অল্প চাপে সিঙ্গাড়া ভেঙে গিয়ে ভুস করে গরম খোঁয়া যদি নাইবা বেরোলো তবে আর সিঙ্গাড়া খাওয়া কেন? মানে গোটা দেশকে সিঙ্গাড়া একটা ঠোঙ্গায় করে নিয়ে এলে যদি চারটের খোল না তুবড়ে যায় তবে সদর্থক সিঙ্গাড়া হল কই? সিঙ্গাড়া তেলে ভাজা হবে আর সেটা তলানো নয় তাই তার গায়ে দু'চারটে লাজুক ক্ষণভঙ্গুর ফলিয়েসিয়াস ফোফা থাকবে বলাই বাহুল্য। এবার আসি পুরের ব্যাপারে। বাঙালি সিঙ্গাড়ায় আলু চটকে মেখে দেয় না। খুদি খুদি ছক্কাপ্রায় আলুর তরকারি যাতে সেক্স মটর, সময় বিশেষে ফুলকপি মেশানো হবে আর তাতে হিং পাঁচফোড়ন সুগন্ধ মম করবে। প্রতি কামড়ে আল্প্রেষের মত লেগে থাকবে আদা কাঁচা লঙ্কার সুগন্ধি স্বাদ। মনে রাখবেন চিনেবাদাম মেশানো হতে পারে কড়াইশুটি নয় ওফ একখানা নিবু নিবু আলোর শীতের বিকেল মনে পড়ে যাচ্ছে এক কাপ আদা দেওয়া চায়ের সাথে ফুলকপির সিঙ্গাড়া। ব্যবহারিক অর্থে সামোসা হল উদরপূর্তি র খাবার আর সিঙ্গাড়া মনোরঞ্জক, তৈরীই হয়েছে স্বাদেদ্রিয়র জন্য। দেখবেন উত্তর ভারতে সামোসা ভেঙে মটরের ঘুঘনি সহযোগে খায়।



SKINTELLECT

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বললে পেতেই যাবেন না, যে রীতিমত দ্বিপ্রাহরিক আহার ওটি। শ্যামবাজারের পাঁচমাথার মোড়ে বা ধনমতলায় আমিও খেয়ে দেখেছি সামোসা চাট। বেশ ভারী জিনিস। সর্বোপরি সিঙ্গাড়া চাটনি দিয়ে খায় না। দুস্বাদু সামোসা গলাধঃকরণ এর জন্য চাটনি লাগবে। কাজের কথাই আসি। কোথায় পাব তারে? অধিকাংশ দোকান ই আজ এই পার্থক্য গুলিয়ে ফেলেছে। কোথাও খোল মোটা তো কোথাও ভেতরে আলুর পুর বিশেষত্বহীন। ল্যাম্পডাউন রোডে বিখ্যাত পুরোনো দোকান মৃত্যুঞ্জয় সুইটস। ঢোকার আগেই লেখা বিখ্যাত ফুলকপির সিঙ্গাড়া। সিজিনেই ছিলাম, সময়েও সন্ধ্যা। আমায় সিঙ্গাড়া দিলেন মাইক্রোওয়েভ এ গরম করে। সে দুঃসহ ব্যথা যে কি বলবা ব্লকবাস্টার ছায়াছবির জঘন্য সিক্যুয়েল দেখে যেরকম লাগে আর কি। আরো বার কয়েক যাচাই করেছি। মন ভরেনি। তুলনায় বাজারাম এর সিঙ্গাড়া ভাল। মন্দের ভালো স্বাদ, দক্ষিণ কলকাতার টালিগঞ্জ এলাকায় কোটাল সত্যনারায়ণ দোকানের। তবে সেও ঐ মাখা পুর। তাহলে ঐ যে সিঙ্গাড়া র ডেসক্রিপশন দিলাম তা কি আর কোথাও পাবো না। তিষ্ঠা। শিয়ালদা য় এন আর এস এর গায়ে যে ফুট ব্রীজ উল্টো ফুটে সিঁড়ি র গায়ে ই বিশেষত্ব হীন আর পাঁচটা মিষ্টির দোকানের মত মা কালী মিষ্টান্ন ভান্ডার। যেমনটি চেয়ে ছিলেন! মাখা হলেও সেই চেনা গন্ধ। বাল। মুচমুচে ভঙ্গুর খোসা। অন্ততঃ বছর দুয়েক আগে অব্দি আমাকে হতাশ করে নি। আমার মনে হয় জেলায় সিঙ্গাড়া জিনিসটা কলকাতার চেয়ে ভালো পাওয়া যায়।

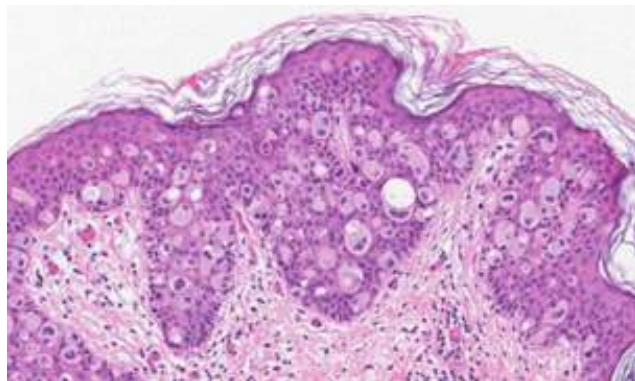
এইবারে লেখার শেষপর্বে যাই। এই যে কথাটা প্রথমেই বলতে চেয়েছি নয়, বলছি। সামোসা থেকে সিঙ্গাড়া আসে নি। ভারতীয় বিভিন্ন প্রকরণ গুলিতো দেখলেন। লুখমি আর chamuca বাদ দিয়ে কোনটাকেই কি সম্বোধন ভারতীয় সংস্করণ মনে হল। আমার মনে হয় ওই ত্রিকোণ সাদৃশ্যের জন্য ভারতের সামোসা শুধুমাত্র নামখানি নিয়েছে। Pastry sheet অর্থাৎ ময়দার লুচি ভাঁজ করার কায়দাতেই ওটা একদম আলাদা হয়ে যাচ্ছে। শঙ্কু বানিয়ে তার মধ্যে পুর ভরে কোনা ভাঁজ করে সিঙাড়া বা সামোসার shape টা লক্ষ করুন। একটা সমতল পার্শ্ব আর একটা বৃত্তল বা স্ফীত উত্তলাকার পার্শ্ব এই তে কোনায় ধরা আছে। সমুচায় দুটি পার্শ্বই উত্তল অর্থাৎ তে কোনা frame এর দুই দিকেই স্ফীত। সামোসা সিঙ্গাড়া র হাজারটা পার্থক্য থাকলেও এই ভাঁজ করার পদ্ধতি এক এবং এটাই ভারতীয় মেজাজের। শুধু নাম সাদৃশ্যে হৃদয়গত মিল নেই সমুচায় সঙ্গে। আমায় জোর দিলেন সুকুমার সেন মহাশয়। তাঁর কলিকাতার কাহিনী থেকে সরাসরি নির্যাস টুকু এবার দি। মন দিয়ে পড়ুন। আটা ময়দা থেকে দুরকম ভাজা আসছে। পুরী তে পুর নেই অর্থাৎ misnomer। আর হল পুরিকা মানে পুর যুক্ত। কচুরী আর ডালপুরি এই গোত্রের। কচুরী মানে হল কাঁচা তরকারী পোরা। ডালপুরি তে ডালের পুর এবার সেটা গোল বা বৃত্তলাকার হলে তাকে বলছি কচুরী আর তে কোনা হলে বলছি সিঙ্গাড়া। তাহলে দুটো জিনিস clear? কচুরি নামে যেটা সাধারণত খাই সেটা ডালপুরি। কড়াইশুটি বা আলু বা পেঁয়াজ পুরে থাকলে সেটা কচুরি। আর কচুরির তে কোণা ভাই হল সিঙ্গাড়া। শৃঙ্গাটক বা পানিফলের সঙ্গে সাদৃশ্য থেকে সিঙ্গাড়া। এবার ভারতীয় কচুরির dizygotic twin কে ইরানেরপোলা যে পারে বলুক। আমি তো না। তাহলে কি বুঝলাম? পারস্যের 'সম্বোসা' থেকে সামোসা নামটুকুই আসতে পারে সিঙ্গাড়া নয়। এ দুটোকে একাকার করে দিয়েছে একালের লঘুমস্তিষ্ক কারিগররা।

কি ক্ষিদে পেল না কমে গেল? তত্ত্বের কচকচি ভুলে যেটা পাওয়া যাচ্ছে সেটাই আনিয়ে ফেলুন না। এই বৃষ্টি মুখর সন্ধ্যাদিনের চায়ের সবচেয়ে প্রিয় সঙ্গী।

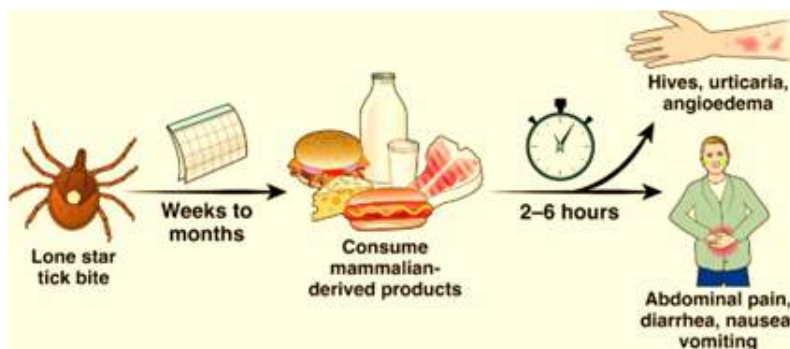


Quiz Zone

1. Drug X is USFDA-approved for psoriasis and seborrheic dermatitis, while Drug Y is a newly approved topical therapy for atopic dermatitis in patients aged 2 years and above. Both target the same molecule. Identify Drugs X and Y.
2. Therapy X is a USFDA-approved ex vivo gene therapy for autosomal recessive dystrophic epidermolysis bullosa, using autologous keratinocytes modified to express COL7A1. Name the therapy X.
3. A 72-year-old woman presented with a 1-year history of an intensely pruritic, erythematous eczematous plaque on the vulva. Topical corticosteroids and antifungals failed to provide lasting relief. A biopsy from the affected area showed the findings in *figure no. 1*, and immunohistochemistry revealed CK7-, CK20+, and CDX2+ cells. Which internal malignancy would you most strongly suspect in this case?
4. Identify the dermoscopic sign depicted in *figure no.2*.
5. Which molecule plays a central role in the pathogenesis of the condition shown in *figure no.3*?



[fig 1]



[fig 3]



[fig 2]

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.



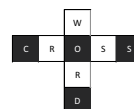
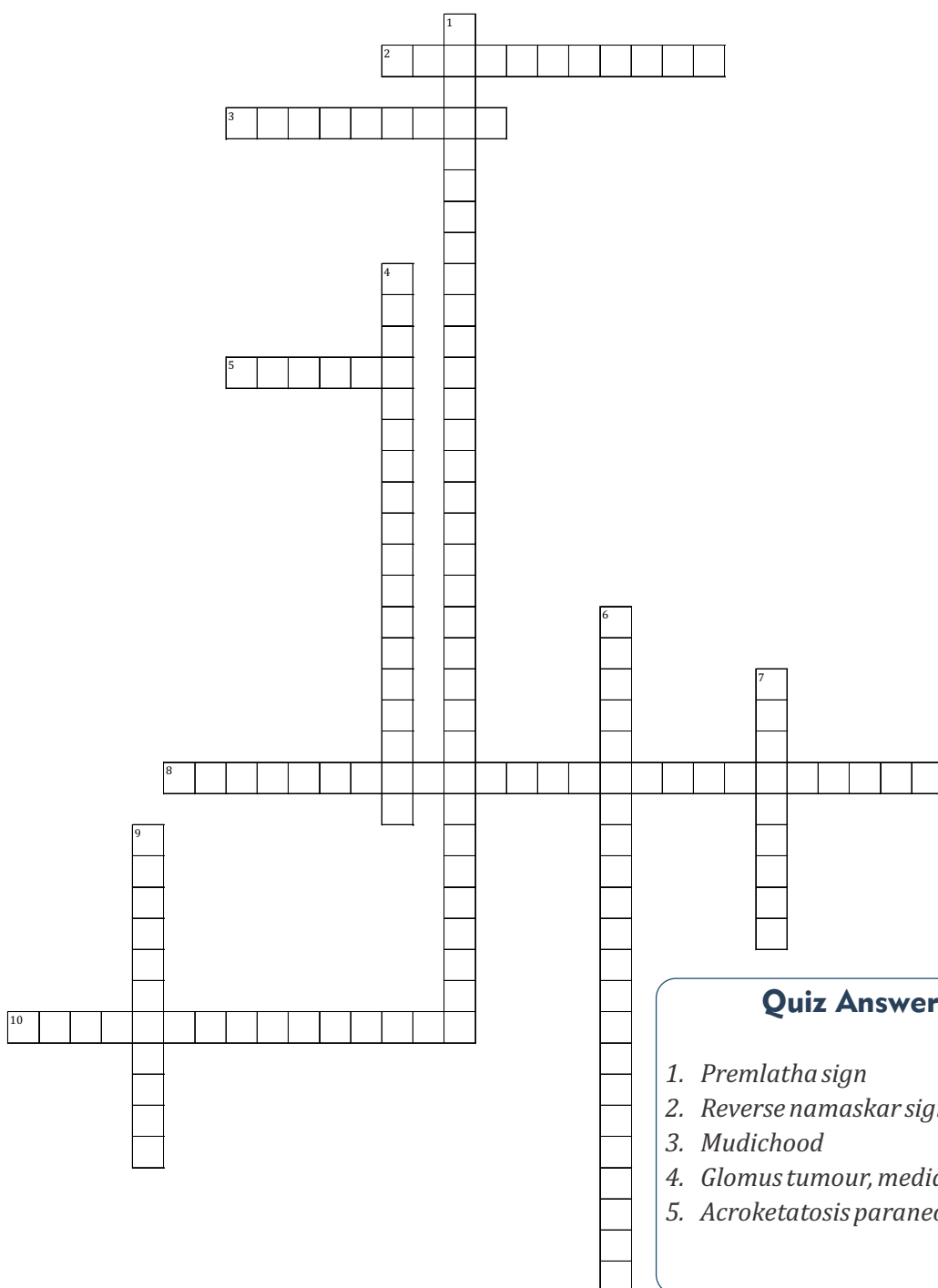
Brainstorm

Across

2. Dominant Phylotype of Cutibacterium acne in Acne
3. Co-receptor tropism assay mandatory before giving
5. Factor determining the wavelength of a LASER
8. Lonafarnib used in
10. Bleeding Nail fold described for

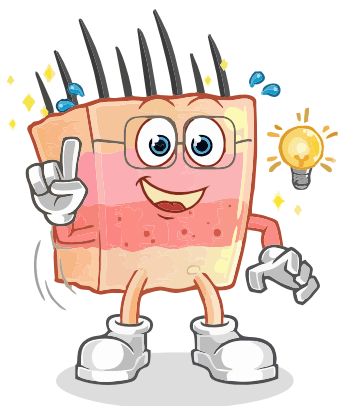
Down

1. Panniculitis with bean bag cells
2. Mulberry appearance in Histopathology
6. Other name for San Joaquin Valley Fever
7. A skin sensitizer obtained from pine family used in adhesives and paints
9. FDA approved KIT inhibitor in advanced Systemic Mastocytosis



Quiz Answer Volume-4, Issue-5

1. *Premlatha sign*
2. *Reverse namaskar sign, Ehler Danlos syndrome*
3. *Mudichood*
4. *Glomus tumour, median canaliform nail dystrophy*
5. *Acroketatosis paraneoplastica of Bazex.*



Dermwiz Answer Volume-4, Issue-5

Xeroderma pigmentosum

Dermwiz

In childhood, daylight challenged me,
And playful knocks left more than you'd see.

Yet strangely, as the years went by,
I feared much less the open sky.

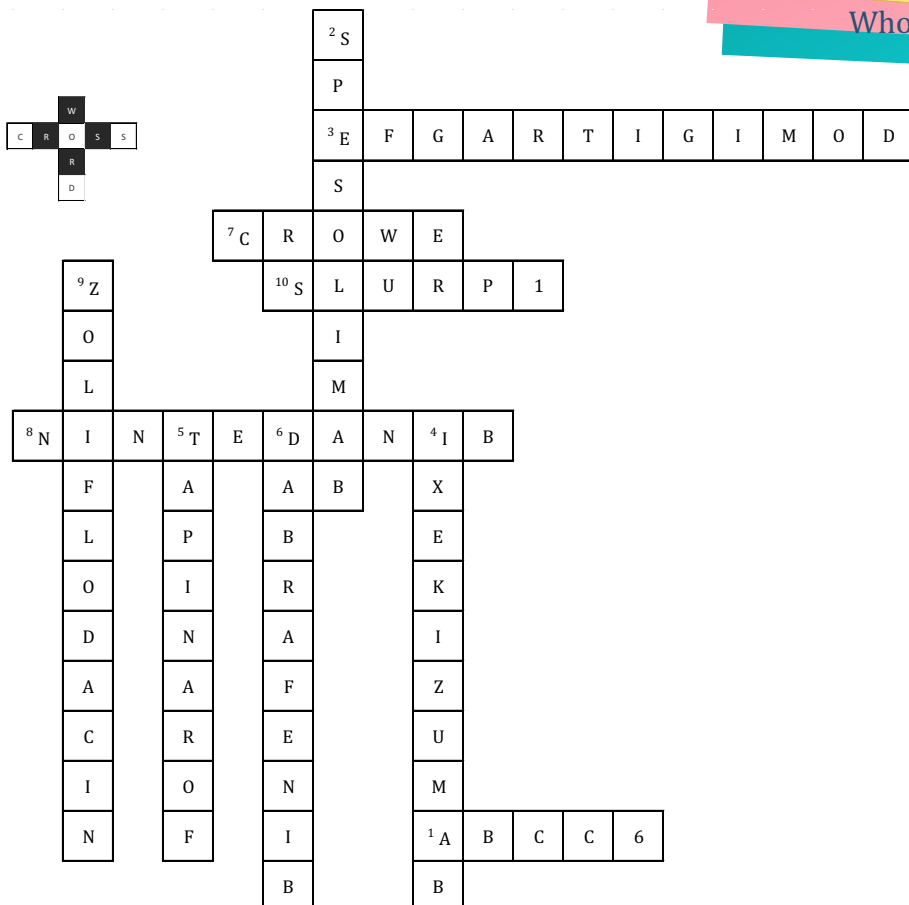
What once would bloom with every fall,
Grew quieter—but not gone at all.

My changing canvas, thin with time,
Wore light and dark in mottled rhyme.

And pathways once both wide and free,
Grew tighter rather silently.

My earliest foe may lose its might,
While later scars continue their fight.

A childhood storm that fades with age—
Who am I upon this changing stage?



Answer
Volume-4, Issue-5



27th - 29th
November 2026

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Award Paper Session

Quiz

Extempore

e poster



ABSTRACT DEADLINE:

15th October 2026

HANDS-ON LEARNING



Dermatopathology



Procedural Dermatology



AI in Dermatology



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