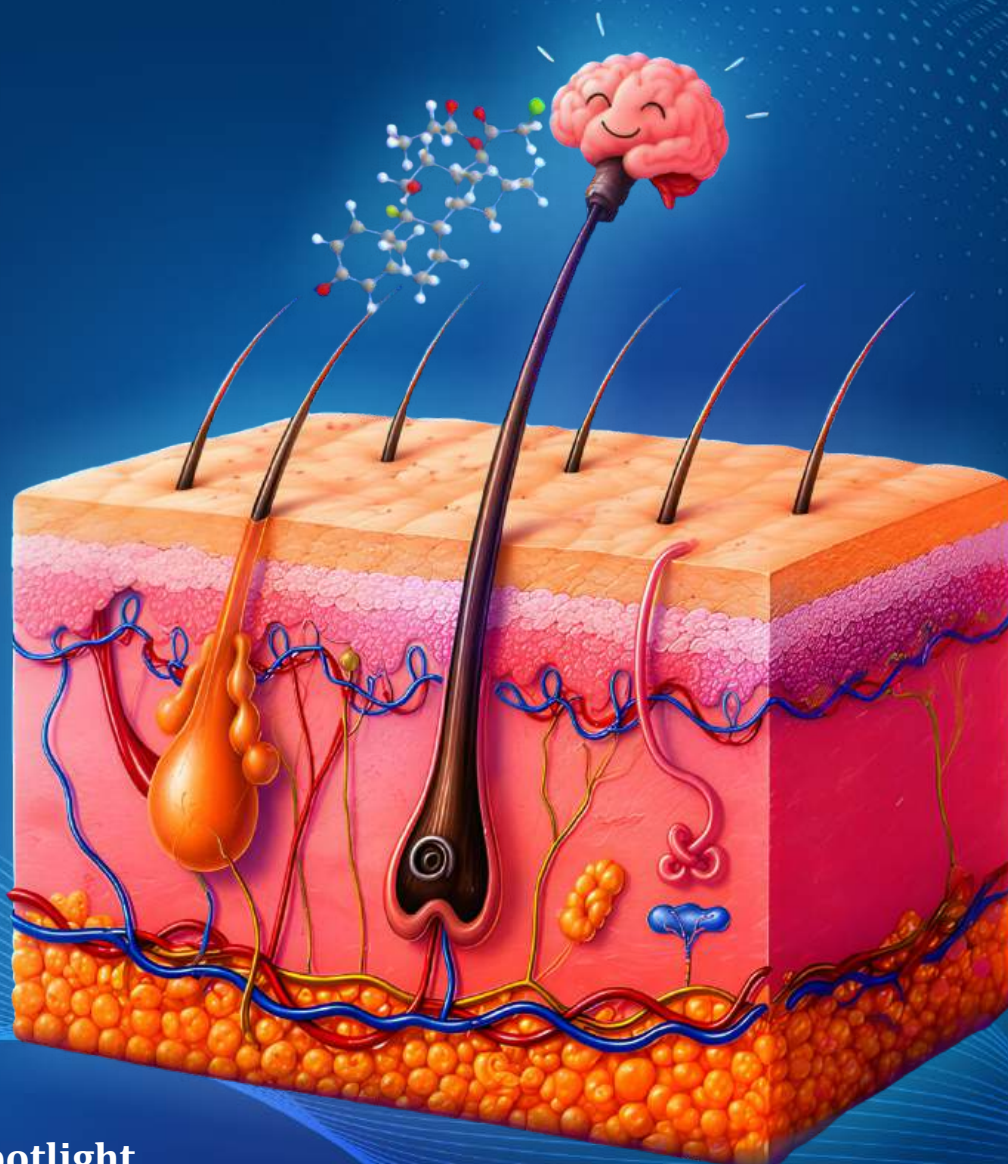


SKINTELLECT

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 7, November 2026



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Note from the President

Dear members,

Warm greetings from IADVL WB.

At the outset I would like to wish all our members and their families on occasion of the just concluded Sri Sri Durga Puja and Navaratri. My regards to all our senior members.

This is a festive season with the ensuing Sri Sri Kali Puja and Chhath Puja but we are also focused on our Dermazone East and CUTICON WB 2026 conference to be held in the last week of November.

I would request all our members to register immediately, if you have not done already, and make the conference a grand success both academically as well as organizationally. We should make sure that our zonal members and other guest faculties feel at home and enjoy every bit of their stay here in West Bengal.

The Organizing Committee under our Organizing Secretary Dr Chinmay Kar and the Scientific Committee under Dr Nilay Kanti Das and the Scientific Secretaries Dr Indrashis Podder and Dr Shahriar Ahmed are working day and night to make this zonal conference memorable. I would request their respective committee members to continue the good work so that no stone is left unturned.

I would like to again compliment Dr Ameli Sarkar and her team of dedicated members for bringing out another issue of Skintellect with unflinching commitment and punctuality even during the festive season.

I wish all our members and their families good health and happiness.

With sincere regards.

Long Live IADVL

Jai Hind



*Dr. Arghyaprasun Ghosh
President
IADVL WB*



Secretary's Scribes

Dear Esteemed Members and Colleagues,

As we celebrate the joyous occasion of Durga Puja, I extend my warmest greetings and heartfelt wishes to all members of IADVL West Bengal and their families. May Maa Durga bless us with good health, happiness, peace, and prosperity, and inspire us to continue serving our profession and society with dedication and compassion.

The past few months have been marked by vibrant academic engagement and meaningful professional collaboration under the banner of IADVL West Bengal. We have successfully conducted several academic programmes, including initiatives by our Special Interest Groups (SIGs) in Dermatology Clinical Research and Psoriasis, along with focused educational activities in paediatric dermatology and other areas of clinical practice. Our participation in national-level academic deliberations and continued efforts towards community outreach through dermatology camps reflect our commitment to advancing dermatological knowledge and delivering quality skin care to society.

Skintellect, our official monthly web journal, continues to serve as an important platform for sharing academic updates, highlighting branch activities, and strengthening communication among members. I sincerely appreciate the editorial team and all contributors for their valuable efforts in keeping this initiative vibrant and informative.

As we embrace the festive spirit, let us renew our commitment to academic excellence, professional unity, and compassionate patient care. May the coming days bring new opportunities for learning, collaboration, and collective growth.

I would also like to extend a warm invitation to all members to join us at Dermazone East, scheduled from 27th to 29th November 2026, at the Biswa Bangla Convention Centre, Kolkata. This important academic gathering will provide an excellent platform for scientific exchange, knowledge sharing, and professional interaction. I encourage all our members to participate enthusiastically and make the event a grand success through their presence and active engagement. Let us come together to strengthen our academic bonds and carry forward the rich tradition of dermatological excellence in Eastern India.

Wishing everyone a very Happy Durga Puja and Shubho Bijoya!

With warm regards,



Dr. Somenath Sarkar
Honorary Secretary
IADVL WB



Editors Desk

Dear Readers,

Shubho Bijoya to everyone! As we bid farewell to the festive charm of Durga Puja, we are delighted to be back with the October issue of Skintellect, bringing you another collection of academic insights, clinical learning, and creative expressions from the dermatology fraternity.

October witnessed an enriching academic endeavour—the Clinical Meet held at KPC Medical College on 28th October—reflecting our continued commitment to learning and professional excellence.

This issue brings you a diverse range of engaging features. In our Spotlight section, Dr Ramesh Chandra Gharami shares his inspiring journey in dermatology. Dr Pratik Dey enlightens us on the various light-based therapies in dermatology, offering valuable insights into their clinical applications. In Case Podium, Dr Aniruddha Ghosh presents an intriguing case of Norwegian scabies, while our Residents' Corner features Dr Moumita Das discussing the evolving concept of drug repurposing in dermatology. Adding a creative touch to this edition, Dr Agnidipa Das shares a beautiful poem inspired by dermatopathology.

We would also like to encourage everyone to register at the earliest for Dermazone East, scheduled from 27th to 29th November. Let us come together to make this academic gathering a grand success!

I sincerely hope you enjoy reading this edition as much as we have enjoyed putting it together. My heartfelt gratitude goes to all our readers, contributors, and well-wishers for their continued support and encouragement. Your enthusiasm inspires us to make Skintellect a vibrant platform for knowledge-sharing, collaboration, and creativity.

Wishing you all happy reading and continued learning!

Warm regards,



Dr. Ameli Sarkar
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CONDOLENCE MESSAGE



Dr. Paritosh Kr. Banerjee

With a heavy heart, we, on behalf of the IADVL West Bengal State Branch, express our profound grief and sorrow at the untimely demise of our esteemed senior life member [LM/WB/2428], Dr. Paritosh Kumar Banerjee, who passed away on 14th October 2026.

As a great leader, Dr. Banerjee held several prestigious positions, including President of IADVL WB in 2002-04, and Hony. Secretary of IADVL WB in 1987-89 and 1994-95.

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

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

With deepest sympathy,

Bereaved Members, IADVL WB



DERMATOLOGIST SPOTLIGHT: DR. RAMESH CHANDRA GHARAMI

Q1. Was dermatology a carefully chosen destination for you, or was it a journey that unfolded along the way?

Engineering was initially my preferred career choice, and I became a medical graduate somewhat unexpectedly. However, choosing dermatology was a carefully considered decision.

Two major factors influenced my choice. First, coming from a modest economic background, I wanted to pursue a specialty that required relatively little initial investment to establish an independent practice after postgraduate training. Second, during my undergraduate days, I witnessed a difficult situation involving my unit professor and a patient's relatives. That experience made me reflect on the nature of professional challenges across different specialties and helped shape my decision to choose dermatology.

There was also a lighter motivation: my dermatology professor owned a car, and I thought that perhaps I, too, could own one someday!

However, as I progressed on my spiritual journey, even that aspiration changed. A car gradually became, for me, simply a means of travelling from one place to another rather than a symbol of achievement or status.

Q2. Which dermatological conditions are most often overdiagnosed or misdiagnosed? Is there an emergency that deserves greater awareness?

In my experience, leprosy and scabies are among the conditions that are frequently misdiagnosed in clinical practice. Greater awareness and careful clinical examination are essential to avoid diagnostic errors and ensure appropriate treatment.

Drug reactions, particularly exanthematous drug eruptions, can be especially challenging. They may closely resemble viral exanthems, making it difficult to distinguish between the two.

One of the most important clinical dilemmas is deciding whether systemic corticosteroids are indicated. This requires careful assessment of the clinical presentation, severity, and possibility of systemic involvement.

Q3. With the changing epidemiology of leprosy, are dermatologists seeing a different spectrum of disease compared with earlier decades?

I have observed two notable changes in the clinical spectrum of leprosy.

First, the occurrence of tuberculoid leprosy appears to be declining, whereas the incidence of borderline lepromatous and lepromatous leprosy seems to be increasing. This is concerning, particularly in the context of our goal of achieving zero leprosy.

Second, I have observed erythema multiforme-like presentations of type 2 lepra reaction, particularly in patients with pure neuritic leprosy. This has been a distinctive observation in my clinical experience that I felt was worth sharing.

Q4. Where do conventional procedures such as electrosurgery and sclerotherapy still hold an edge? Which lesions are particularly suitable for sclerotherapy?

In my experience, electrosurgery can achieve results comparable to those of CO₂ laser in a large proportion of cases, perhaps as many as 90%.

Sclerotherapy, however, has its own unique place in dermatological practice. The key is to understand its indications and select appropriate cases.





I have used sclerotherapy for a wide range of conditions, including vascular lesions, cystic acne, epidermal cysts, mucocoeles, and hidradenitis suppurativa, with very encouraging results.

I believe that conventional procedures continue to have considerable value. Their success depends not merely on the availability of advanced equipment but also on the clinician's understanding of the procedure, appropriate case selection, and practical experience.

Q5. Do you believe every dermatologist should develop the ability to interpret skin biopsies independently?

Learning histopathology is very important during postgraduate training, as pathologists are often not fully aware of the clinical scenario. Therefore, being entirely dependent on their reports is not a good approach. Every postgraduate student should focus on learning histopathology from their teachers with the utmost importance.

Q6. Beyond dermatology, you have a deep interest in spirituality and follow Vaishnavism. How has your spiritual journey influenced your life and approach to medicine?

According to the Srimad Bhagavatam, human life can be understood as a progressive journey: we perform our duties to become religious, cultivate renunciation through religious practice, and develop renunciation to attain love for the Supreme Lord, Sri Krishna.

Ultimately, we seek that divine love because our deepest aspiration is to attain genuine happiness.

This philosophical progression, as I understand it from the Srimad Bhagavatam, has profoundly influenced my outlook on life. I am trying to follow these principles and implement them in my practical life.

Spirituality has gradually changed my understanding of success, material possessions, and the purpose of human existence. I believe that our professional responsibilities should also be performed with sincerity, compassion, and a sense of purpose, rather than being driven solely by material achievements.

Q7. Can spirituality change the way we understand the relationship between physical appearance and identity?

I would like to answer this question through a simple story involving a crow, a peacock, and a cuckoo.

One day, they began sharing their insecurities. The crow said to the cuckoo, "Both of us are black, but your voice is so melodious that everyone appreciates you. When I make a sound, people dislike it and sometimes even throw stones at me."

The cuckoo, in turn, lamented that although its voice was beautiful, it lacked the colourful feathers of the peacock.

The peacock, meanwhile, felt that it could neither sing as melodiously as the cuckoo nor contribute to the environment in the way the crow did.

Each bird admired the qualities of the others while overlooking its own strengths.

The moral is simple: everyone possesses certain qualities, and everyone has limitations. We often become dissatisfied when we compare ourselves with others, forgetting the value of what we already possess.

Similarly, in human life, physical appearance is only one aspect of our identity. We should learn to value inner qualities, character, compassion, and spiritual development more than external appearance.

This is where spirituality becomes relevant. It helps us look beyond the body and its appearance, understand our deeper identity, and recognise the true purpose of life.

DERMBUZZ :

WHEN LIGHT HEALS: EXPLORING PHOTOTHERAPY FOR SKIN

Ultraviolet (UV) radiation forms a part of the electromagnetic spectrum and it has been used as a controlled therapeutic tool in dermatology. Phototherapy is defined as the therapeutic use of UV radiation. It is one of the key components in the management of several chronic, dermatosis, inflammatory diseases mainly and has a vital role in management of pigmentary disorders like vitiligo. This article reviews the types of UV radiation, their mechanism of action, therapeutic indications, protocols, safety profile and future directions.

INTRODUCTION

The relationship between skin and sunlight is as ancient as it is complicated. Excess UV radiation exposure is harmful for the skin whereas controlled UV radiation is therapeutic. This paradox is what makes phototherapy interesting- complex to study and utilised in therapy.

Phototherapy in dermatology was used in 1893 by Niels Finsen, where he used filtered sunlight to treat cutaneous Lupus Vulgaris. Later he went on to win the Nobel Prize in 1903. In current times, phototherapy is considered to be a cost-effective and safe modality, mainly because of its use as a non-steroidal alternative in resource-limited settings.

The UV spectrum is divided into UVC (200-290 nm, blocked by ozone), UVB (290-320 nm) and UVA (320-400 nm). For dermatological therapy, the wavelengths used are UVB (BB UVB and NB UVB) and UVA.

MECHANISM OF ACTION OF UV RADIATION IN SKIN

UV radiation influences multiple immunological and cellular pathways:

1. **Immunosuppressive Effect:** UVB depletes Langerhans cells, APCs of epidermis, induces migration of regulatory T cells. It shifts the cytokine profile- from pro-inflammatory Th1/Th17 to anti-inflammatory Th2 type. It induces apoptosis of infiltrating pathogenic T-lymphocytes - the key mechanism in psoriasis and cutaneous T-cell lymphoma. [1]
2. **Anti-proliferative Effect:** In psoriasis, keratinocyte turnover is rapid. UV radiation arrests cell cycle and inhibits DNA synthesis, thus slowing down rapid epidermal proliferation. [1]
3. **Anti-pruritic Effect:** UV reduces NGF and modulates cutaneous sensory nerve endings helping pruritic dermatosis like atopic dermatitis and prurigo nodularis.
4. **Melanogenic Effect:** UV stimulates melanocyte proliferation, migration of melanosomes and enhances tyrosinase activity aiding in vitiligo repigmentation.
5. **Anti-fibrotic Effect:** UVA1 penetrates deep in dermis and induces collagenase activity (MMP-1) and causes apoptosis of fibroblasts thus helping in treating morphea and scleroderma. [5]

TYPES OF PHOTOTHERAPY IN USE:

A. Narrowband UVB (NB-UVB - 311±2 nm):

Gold standard. It is the most effective wavelength with minimal erythemogenicity. Advantages: no psoralen needed, safe in children and pregnancy, can be given with minimal eye protection, lower carcinogenic risk than PUVA.

B. Broadband UVB (BB-UVB - 290-320 nm):

It has more burning potential and is less efficacious, hence largely replaced by NB-UVB.

C. PUVA - Psoralen + UVA:

Psoralen is a photosensitizer that interacts with DNA. On UVA exposure, it forms cross-links and inhibits proliferation. Types: Oral PUVA, Bath PUVA, Bath-soak and Topical PUVA. More effective than NB-UVB in some indications but needs strict eye protection for 24 hours and has higher long-term skin cancer risk. Oral formulations cause gastric irritation. Ophthalmologic follow-up required.

Dr. Pratik Dey

Asst. Professor, Dept. Of DVL
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D. UVA1 (340-400 nm):

Low, medium and high dose UVA1. It has deeper penetration and works well for atopic dermatitis (acute phase), morphea, systemic sclerosis, mycosis fungoides and urticaria pigmentosa. But the major limitations include cost and heat generation.

E. Targeted Phototherapy:

308 nm Excimer laser and Excimer lamp delivers supramaximal dose limited to lesional skin only. Best for localized vitiligo (<10% BSA), localized psoriasis, alopecia areata patches and palmoplantar dermatoses. Requires fewer sessions but costly.

THERAPEUTIC INDICATIONS - EVIDENCE BASED

1. Psoriasis: NB-UVB is first-line for moderate-to-severe chronic plaque psoriasis, guttate psoriasis. PUVA is preferred for palmoplantar pustular psoriasis and thick plaques. Combination with acitretin (Re-NB-UVB) is preferred in palmoplantar psoriasis. [1]
2. Vitiligo: NB-UVB is the treatment of choice for non-segmental generalized vitiligo. It induces perifollicular repigmentation. Needs at least 6-12 months therapy. Excimer laser is superior for segmental and localized vitiligo, face and neck lesions respond best. Combination with topical tacrolimus enhances outcome.
3. Atopic Dermatitis: NB-UVB is second-line after topicals. It reduces colonization of *S. aureus*, pruritus and need for systemic steroids. UVA1 is better for acute, severe, exudative atopic dermatitis.
4. Cutaneous T-Cell Lymphoma (Mycosis Fungoides): NB-UVB for early patch stage (T1), PUVA for plaque stage (T2). It induces apoptosis of clonal T-cells.
5. Phototherapy is also found effective in-
 - Pityriasis lichenoides chronica
 - Parapsoriasis
 - Lichen planus
 - Prurigo nodularis
 - Alopecia areata (Excimer)
 - Morphea and Lichen sclerosus (UVA1)
 - Uremic pruritus and Aquagenic pruritus
 - Polymorphic light eruption (photo-hardening)

PROTOCOL AND DOSIMETRY

Standard protocol: 2-3 sessions per week on non-consecutive days. Initial dose based on Fitzpatrick skin type (Type IV-V common in India: 280-350 mJ/cm² for NB-UVB) or Minimal Erythema Dose (MED). Dose increments of 10-20% if no erythema. If mild erythema persists, hold dose. If painful erythema/blistering, skip and reduce by 50%.

Whole-body cabinet for generalized disease, hand-foot unit for palmoplantar lesions.

Mandatory: UV-opaque goggles, genital shield for males, face shield if face not affected, thorough counselling about photoprotection.

CONTRAINDICATIONS AND SAFETY

Absolute Contraindications: Photosensitive disorders- Xeroderma pigmentosum, Albinism, Lupus erythematosus, history of melanoma, etc.

Relative: History of non-melanoma skin cancer, use of photosensitizing drugs (doxycycline, thiazides), pacemakers. [3]



Adverse Effects:

Acute: Erythema, dryness, pruritus, exacerbation of herpes, nausea due to PUVA.

Chronic: Photoaging, lentigines, keratoses. Long-term PUVA >200 sessions increases risk of squamous cell carcinoma. No such risk for NB-UVB. [3]

NB-UVB is safe in children, pregnancy and lactation.

FUTURE PERSPECTIVES

The future of phototherapy is targeted and personalized.

1. Home-based NB-UVB units- to improve compliance
2. Combination with biologics- to reduce burden of biologics. [2]
3. Low-dose UVA1 cold light devices.
4. Photodynamic Therapy and blue/red light for acne.
5. AI-based dosimetry and MED calculation.
6. LED-based NB-UVB - low cost, portable.

Recent advances:

● **Physician-Directed Home Phototherapy:**

- FDA-cleared and guided home phototherapy units (such as the Fautherra device) use digital step-by-step controllers and research-backed safety protocols to manage dosing at home for conditions like psoriasis, eczema, and vitiligo.
- Clinical data (such as the Light Study) show that home phototherapy significantly improves patient adherence and treatment convenience over traditional in-office visits.

● **Synergistic Combination Protocols:**

- Combining NB-UVB or targeted phototherapy with systemic or topical agents (such as JAK inhibitors) enhances melanocyte repigmentation in vitiligo and clears recalcitrant psoriasis faster.

● **Balneophototherapy and Specialized Wavelengths:**

- The integration of saltwater brine or 8-methoxypsoralen (PUVA) baths prior to UVA/UVB exposure continues to optimize outcomes for extensive psoriasis and atopic dermatitis with lower systemic drug burdens. [4]

CONCLUSION

In the era of boom in biologics and JAK inhibitors use, UV radiation remains the most effective, economical treatment modality and without systemic immunosuppression. An astute physician would advocate the use of phototherapy in various dermatological diseases in adjunct to or as an alternative to therapies carrying significant side effects. The art lies in controlling the dose.

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RESIDENT'S CORNER: DRUG REPURPOSING IN DERMATOLOGY

1. Introduction

The development of a new therapeutic agent is often a lengthy, costly, and uncertain process. In contrast, drug repurposing offers an alternative approach by exploring new therapeutic applications for existing drugs with established pharmacological profiles. Also known as drug repositioning, this strategy has gained increasing relevance in modern medicine, including dermatology, where advances in the understanding of disease pathogenesis continue to reveal new possibilities for familiar therapeutic agents.

Dermatology offers a particularly interesting landscape for drug repurposing. Despite their diverse clinical presentations, many cutaneous disorders share similar underlying pathogenic mechanisms, including immune dysregulation, chronic inflammation, altered keratinisation, aberrant cellular proliferation, and hormonal signalling. These overlapping pathways create opportunities for drugs developed for one dermatosis to demonstrate therapeutic activity in another. The accessibility of the skin for topical drug delivery further facilitates the exploration of new therapeutic applications.

However, not every additional use represents an approved indication. Some applications are supported by substantial

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No	Drug	Original indication	New/expanded indication	Status of new use
1.	Clascoterone	Acne Vulgaris	Androgenetic Alopecia	Investigational
2.	Tazarotne	Psoriasis	Acne vulgaris, photoaging	Approved
3.	Topical Roflumilast	Plaque psoriasis	Seborrheic dermatitis, atopic dermatitis, vitiligo, lichen planus	Approved (SD, AD); off-label (vitiligo); investigational (LP)
4.	Azelaic acid	Acne	Rosacea, melasma	Approved (rosacea); off-label (melasma)
5.	Cyclosporine	Psoriasis	Atopic dermatitis, Alopecia areata	Approved in many regions (AD); off-label (AA)
6.	Tapinarof	Plaque psoriasis	Atopic dermatitis	Approved
7.	Topical Ruxolitinib	Atopic dermatitis	Non-segmental vitiligo, AA	Approved (vitiligo); investigational (AA)
8.	Apremilast	Psoriatic arthritis	LP, hidradenitis suppurativa (HS), Hailey-Hailey disease, discoid lupus (DLE)	Off-label
9.	Acitretin	Pustular Psoriasis	Darier disease, pityriasis rubra pilaris (PRP), LP	Off-label
10.	Dapsone	Dermatitis herpetiformis (and leprosy)	Sweet syndrome, pyoderma gangrenosum, other neutrophilic dermatoses	Off-label



No	Drug	Original indication	New/expanded indication	Status of new use
11.	Hydroxychloroquine	Autoimmune LE (originally malaria)	LP, lichen planopilaris	Off-label
12.	Methotrexate	Psoriasis	Atopic dermatitis, AA	Off-label
13.	Dupilumab	Atopic dermatitis	Prurigo nodularis (also CSU, bullous pemphigoid)	Approved

clinical evidence, whereas others remain investigational or off-label. Distinguishing these categories is essential to avoid overstating therapeutic efficacy.

AA, alopecia areata; AD, atopic dermatitis; AGA, androgenetic alopecia; CSU, chronic spontaneous urticaria; DLE, discoid lupus erythematosus; HS, hidradenitis suppurativa; LP, lichen planus; PRP, pityriasis rubra pilaris; SD, seborrhoeic dermatitis. Regulatory status varies by country and changes over time; "approved" refers mainly to US FDA labelling.

2. Topical agents

Retinoid and anti-androgen: tazarotene and clascoterone. Tazarotene, a receptor-selective retinoid (RAR- β/γ), was first approved for plaque psoriasis and later for acne vulgaris and mild facial photodamage, reflecting the normalisation of keratinocyte differentiation, comedolysis and dermal remodelling that retinoids share across these conditions.

Clascoterone, a topical androgen-receptor inhibitor with minimal systemic absorption, is approved for acne vulgaris in patients aged 12 years and older after two phase 3 trials. Since androgen signalling in the follicle drives both acne and androgenetic alopecia, clascoterone has been evaluated as a topical, non-systemic alternative to finasteride-type therapy in AGA; this use remains investigational.

Azelaic acid. This dicarboxylic acid inhibits tyrosinase and keratinocyte hyperproliferation, has antimicrobial activity against *Cutibacterium acnes* and reduces kallikrein-5 and cathelicidin expression. These actions explain its progression from acne to papulopustular rosacea (approved) and to melasma and post-inflammatory hyperpigmentation, where it is widely used off-label and is generally well tolerated.

PDE4 inhibition and AhR modulation: roflumilast and tapinarof. Phosphodiesterase-4 inhibition raises intracellular cAMP and dampens production of TNF- α , IL-17, IL-23 and other cytokines. Oral roflumilast was developed for COPD; roflumilast 0.3% cream was approved for plaque psoriasis after the DERMIS trials and the indication has since extended to seborrhoeic dermatitis (foam) and atopic dermatitis (cream), with early reports in vitiligo and lichen planus. Tapinarof, a non-steroidal aryl hydrocarbon receptor agonist that also activates the Nrf2 antioxidant pathway and downregulates Th17 cytokines, was approved for plaque psoriasis after the PSOARING trials and subsequently for atopic dermatitis. Both agents are steroid-sparing options suitable for intertriginous and facial skin.

Topical JAK inhibition: ruxolitinib cream. Ruxolitinib, a JAK1/2 inhibitor first developed as an oral agent for myelofibrosis, was formulated as a 1.5% cream for mild-to-moderate atopic dermatitis. Because interferon- γ driven JAK-STAT signalling sustains autoimmune melanocyte destruction, it was then tested in vitiligo; the TRuE-V trials showed significantly greater facial repigmentation and led to approval for non-segmental vitiligo in patients aged 12 years and older. Evidence for topical ruxolitinib in alopecia areata is limited, and the established benefit in AA comes from oral JAK inhibitors such as baricitinib.



3. Conventional systemic agents

Methotrexate and cyclosporine. Methotrexate, a folate antagonist that also increases extracellular adenosine, was first used in oncology and then in psoriasis. In severe atopic dermatitis it has shown efficacy comparable to azathioprine, and it is used off-label in alopecia areata, often with low-dose corticosteroids. Cyclosporine, a calcineurin inhibitor that suppresses T-cell IL-2 transcription, was developed for transplant rejection and became a rapid-acting treatment for psoriasis; it is now an established short-term option for severe atopic dermatitis and has been reported in recalcitrant AA. Nephrotoxicity and hypertension restrict continuous use to about one to two years, whereas methotrexate requires monitoring of hepatic and haematological parameters.

Acitretin. This second-generation oral retinoid is most often used for severe or pustular psoriasis, in which it is effective as monotherapy or with phototherapy. Through normalisation of epidermal differentiation it also benefits keratinisation disorders such as Darier disease and pityriasis rubra pilaris, and it is used in lichen planus. Teratogenicity (with a need for contraception for three years after therapy), mucocutaneous dryness and hyperlipidaemia are the main constraints.

Dapsone. Originally an antileprosy drug and the treatment of choice for dermatitis herpetiformis, dapsone inhibits neutrophil myeloperoxidase and chemotaxis. This anti-neutrophil activity underlies its off-label use in Sweet syndrome, pyoderma gangrenosum and other neutrophilic dermatoses. G6PD status must be checked before starting, and haemolysis and methaemoglobinaemia should be monitored.

Hydroxychloroquine. Developed as an antimalarial, hydroxychloroquine interferes with lysosomal antigen processing and Toll-like receptor 7/9 signalling. It is a first-line agent for cutaneous lupus and is also used in lichen planus and lichen planopilaris. Baseline and periodic ophthalmological screening for retinopathy is required.

4. Targeted oral and biologic therapies

Apremilast. This oral PDE4 inhibitor is approved for plaque psoriasis, psoriatic arthritis and oral ulcers of Behcet disease, with a favourable monitoring profile. Case series and small trials suggest benefit in lichen planus, hidradenitis suppurativa, Hailey-Hailey disease and discoid lupus erythematosus and these uses remain off-label.

Dupilumab. By blocking the shared IL-4/IL-13 receptor subunit, dupilumab produced robust improvement in moderate-to-severe atopic dermatitis. Because the same type 2 axis, together with neuroimmune itch circuits, drives prurigo nodularis, phase 3 trials demonstrated reductions in itch and nodule counts and led to approval for this indication. Further type 2-mediated conditions, including chronic spontaneous urticaria and bullous pemphigoid, have since been added to its labelling in some regions.

5. Challenges and future directions

Despite their promise, repurposed drugs face practical hurdles. Many uses rest on case reports, small series or retrospective cohorts, so the quality of evidence varies widely. Off-label prescribing carries medico-legal difficulties. Newer agents such as JAK inhibitors, roflumilast and tapinarof are costly, and long-term safety data in the new indications are still accumulating, including class-specific JAK safety warnings. Dose, formulation often require re-optimisation for the new disease site. Future progress is likely to come from computational and network-based drug matching, biomarker-guided patient selection and investigator-led pragmatic trials of inexpensive drugs.

6. Conclusion

Repurposing has repeatedly broadened the dermatological resources, from the early extension of retinoids, methotrexate and dapsone to modern topical PDE4, AhR and JAK modulators. The common lesson is that shared inflammatory pathways link seemingly unrelated dermatoses, so a drug validated in one disease is a rational candidate in another. Clinicians should match the strength of evidence and regulatory status of each use to individual patients, while the field continues to generate high-quality trials to move promising off-label uses into guideline-supported practice.



CASE-PODIUM: NORWEGIAN SCABIES IN A 21-YEAR-OLD POSTPARTUM FEMALE

Norwegian \crusted scabies is a severe highly contagious form of scabies characterized by massive proliferation of *sarcoptes scabiei* mites producing extensive hyperkeratotic crusted lesions. Unlike classical scabies it may occur with little or no pruritic, particularly in immunocompromised patients, and is associated with an extremely high mite burden.

A 21-year-old postpartum female presented to the emergency with complaints of nausea vomiting and headache for 1 week and with a previous diagnosis of pityriasis rubra pilaris. Patient was unconscious with severe anemia, hypoalbuminemia, hypernatremia and hypokalemia. She was referred to us for generalized redness and scaling unresponsive to steroids and cyclosporine. She also had multiple roundish ulcerated grouped lesions with oozing and crusting around the mouth which were painful suggestive of herpes labialis.

Investigations done were koh mount and tzanck smear, the former on inspection under the microscope showed us numerous *sarcoptes scabiei* mites and eggs of the same. Tzanck smear was inconclusive. With the above findings we treated the patient with ivermectin following the 7-day regimen 12 MG oral ivermectin on day 1,2,8,9,15,22,29. There was complete resolution of the scaling and erythroderma

The differential diagnosis are pityriasis rubra pilaris, psoriasis,

Dr. Aniruddha Ghosh
Prof., Dept. of Dermatology,
JIMS, Budge Budge



Figure 1:
Scaling and erythema



Figure 2:
Scabies Mite and Eggs



Figure 3:
Before and after treatment
with Oral Ivermectin

DERMA Abahan: Season 2 Episode 3 on 29/10/2026

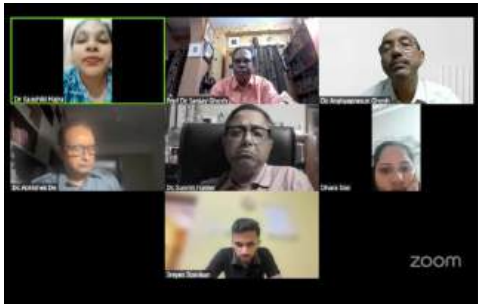
In observation of World Psoriasis Day Webinar on Psoriasis: An update

Observing World Psoriasis Day with IADVL WB Academy's "Derma Abahan"

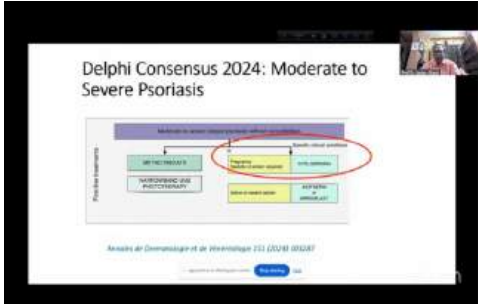
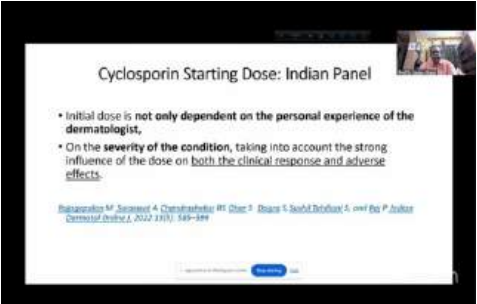
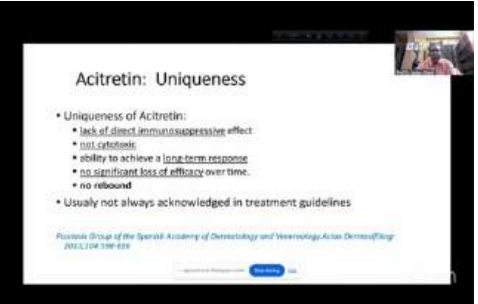
In observation of World Psoriasis Day, the IADVL WB Academy presented Season 2, Episode 3 of "Derma abahan: The Scientific Reckoner" on 29th october. Hosted by Dr. Kaushiki Hajra, the virtual webinar commenced with a welcome address by Dr. Arghyaprasun Ghosh, President of IADVL WB.

The academic schedule featured three insightful presentations on the comprehensive management of psoriasis. Dr. Sanjay Ghosh opened the scientific sessions with an evaluation of the present scenario of conventional systemics and recent topical weapons. Following this, Dr. Abhishek De offered a practical Indian perspective on when to initiate biologics in psoriasis. Dr. Sudip Kr. Ghosh then expanded the clinical focus beyond the skin, addressing the critical question of whether comorbidities are being missed in psoriasis management.

The lectures were followed by a robust, case-based panel discussion focusing on difficult clinical scenarios in psoriasis. Moderated by Dr. Sk Shahriar Ahmed, the expert panel included Dr. Abhishek De, Dr. Dibyendu Basu, Dr. Sudip Kr. Ghosh, Dr. Sudipta Roy, and Dr. Susmit Halder. This enriching educational initiative concluded with closing remarks by Dr. Sumit Sen, Academy Chair of IADVL WB, and a vote of thanks delivered by the Honorary Secretary, Dr. Somenath Sarkar.












DERMAGINATIONS: PAGING PASSION BEYOND PRACTICE

THE POETRY OF DERMATOPATHOLOGY

Where the skin writes its story in cells, vessels and scars

Homeostasis keeps the quiet balance,
A living rhythm, a measured dance.
Then **inflammation** sounds its call—
The first response when barriers fall.

Ischaemia starves, **thrombosis** blocks,
Infarction follows when perfusion stops.
Oedema gathers, **haemorrhage** stains,
Extravasation lets blood escape its lanes.

When cells can no longer survive,
Necrosis marks the loss of life.
Apoptosis chooses a quieter way—
A cell bows out without disarray.

Then comes **lysis**, breaking down the past,
While **phagocytosis** clears what cannot last.
The debris is gone; the battlefield still—
But the skin has another story to fulfil.

And then comes repair.

Granulation rises from the wounded floor,
Angiogenesis opens vessels once more.
Proliferation builds; **regeneration** restores,
Remodelling reshapes what the injury tore.

Yet healing does not always return things the same—
Sometimes **fibrosis** signs its name.
Sclerosis hardens what once was tender,
And **scar** becomes the skin's quiet surrender.

Not defeat.
Not merely a flaw.

But evidence—

Dr (Maj) Agnidipa Das
PGT Dept of DVL
KPC MCH



that something happened here,
and the body tried to repair it all.

The epidermis has poetry of its own.

Keratinisation builds the barrier strong,
Hyperkeratosis makes the horny layer long.

Parakeratosis keeps nuclei in sight,
Where they should have vanished by maturation's rite.

Dyskeratosis—keratinisation gone astray,
A troubled keratinocyte changing its way.

Spongiosis lets fluid slip between,
Giving the epidermis a swollen sheen.

Acantholysis breaks the bonds cell to cell,
Exocytosis lets inflammatory cells enter as well.

Papillomatosis raises the surface high—
A microscopic landscape beneath the eye.

And the tissue changes with time.

Atrophy whispers: there is less.
Hypertrophy answers: make each cell excess.
Hyperplasia says: make the numbers grow.
Metaplasia says: change what you know.



Degeneration alters what once was sound;
Calcification leaves mineral on the ground.
Hyalinisation turns tissue pale and glassy,
While **fibrosis** makes healing permanent—and lasting.

Then the vessels tell their tale.

Vasculitis turns against the vessel wall,
Vasculopathy changes the circulation overall.
Congestion slows; **ischaemia** deprives,
And every vessel records
the struggle of tissues to remain alive.

The Dermatopathologist reads all of this—

Not simply a lesion.
Not merely a slide.

But a sequence.

Balance → Injury → Inflammation → Death →
Clearance → Repair → Remodelling →
Scar.

Or, in the language of the skin:

Homeostasis → Ischaemia → Necrosis → Lysis →
Granulation → Proliferation → Regeneration →
Fibrosis → Scar.

A diagnosis may have a name.

But beneath that name lies a story—

of cells that suffered,
vessels that responded,
tissues that adapted,
and a skin that refused
to remain silent.

Because dermatopathology is not just the study of what
the skin has become.

It is the poetry of everything that happened to make it so.



Quiz Zone

- 1) Independently developed and approved by China in 2025 for use in moderate to severe psoriasis, X is a unique monoclonal antibody against p19 subunit of IL-23 which prevents binding of IL-23 to its receptor offering a 12 weekly dosing interval. Identify X.
- 2) Approved in 2026. Y is a novel antiretroviral drug which has a unique dual mechanism of action by inhibiting viral reverse transcriptase and impeding translocation of the enzyme along the viral RNA chain (Nucleoside/nucleotide reverse transcriptase translocation inhibitor). Identify Y.
- 3) A 50 year old man presented with the following skin lesions demonstrating a specific sign. (Figure 1). Connect the two images in Figure 1 and name the disease as well as the sign being referred to.
- 4) Mrs. G presented to the OPD with joint pain and muscle weakness involving the muscles of the shoulder girdle and hip girdle. On examination, violaceous edema of the eyes was noted and skin lesions as depicted in figure 2 was observed. Identify this rare entity.
- 5) A 2 year old girl was brought to the OPD with history of total absence of hair from birth. She was on antiepileptic medications since the last 1 year and showed delayed developmental milestones. Connect the triad of features and state the diagnosis.



[fig 1]

[fig 2]



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.



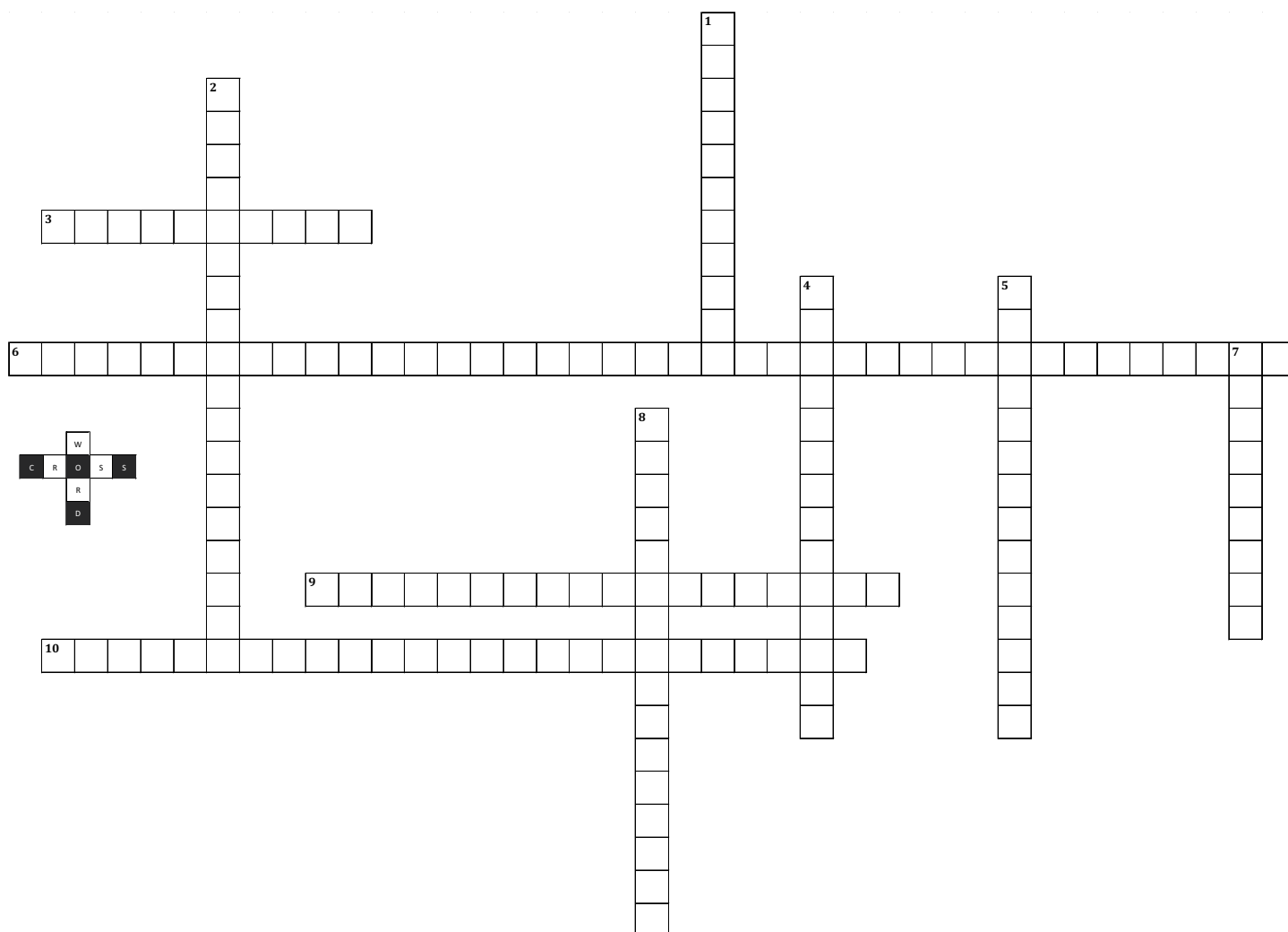
Brainstorm

Across

3. PDE4 inhibitor ointment FDA approved for mild to moderate Atopic dermatitis
6. Trizonal concentric pattern in Dermoscopy seen in
9. Alligator boy
10. Systemic tolerance induced by feeding an allergen before attempted contact hypersensitivity

Down

1. Antiviral drug causing yellow green fluorescence oh hair, nail and sclera underwood's lamp
2. Strasbourg Diagnostic criteria used in
4. Pizza sign in HPE
5. Method pioneered by Julius Wagner-Jauregg
7. ART with retinoid like side effect
8. Derivative of Penicillium brevicompactum



Quiz Answer Volume-4, Issue-6

1. Drug X is Roflumilast & Drug Y is Difamilast (Difamilast 1% ointment has been approved by USFDA in February 2026 for treating mild to moderate atopic dermatitis 2 years of age & above).
2. Prademagene zamikeracel.
3. Colorectal malignancy.
4. Parallel furrow sign in case of benign nevus.
5. α Gal or galactose α 1,3 galactose (Given picture depicts α gal syndrome).

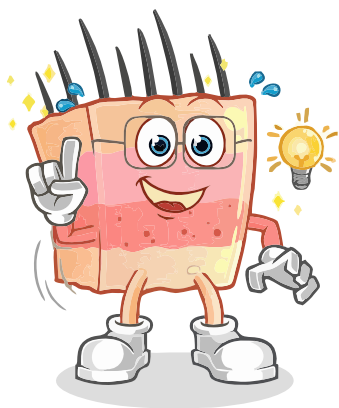


SKINTELLECT

The Official Newsletter of the IADVL West Bengal State Branch



Volume 4 Number 07
November 2026



Dermwiz Answer
Volume-4, Issue-6

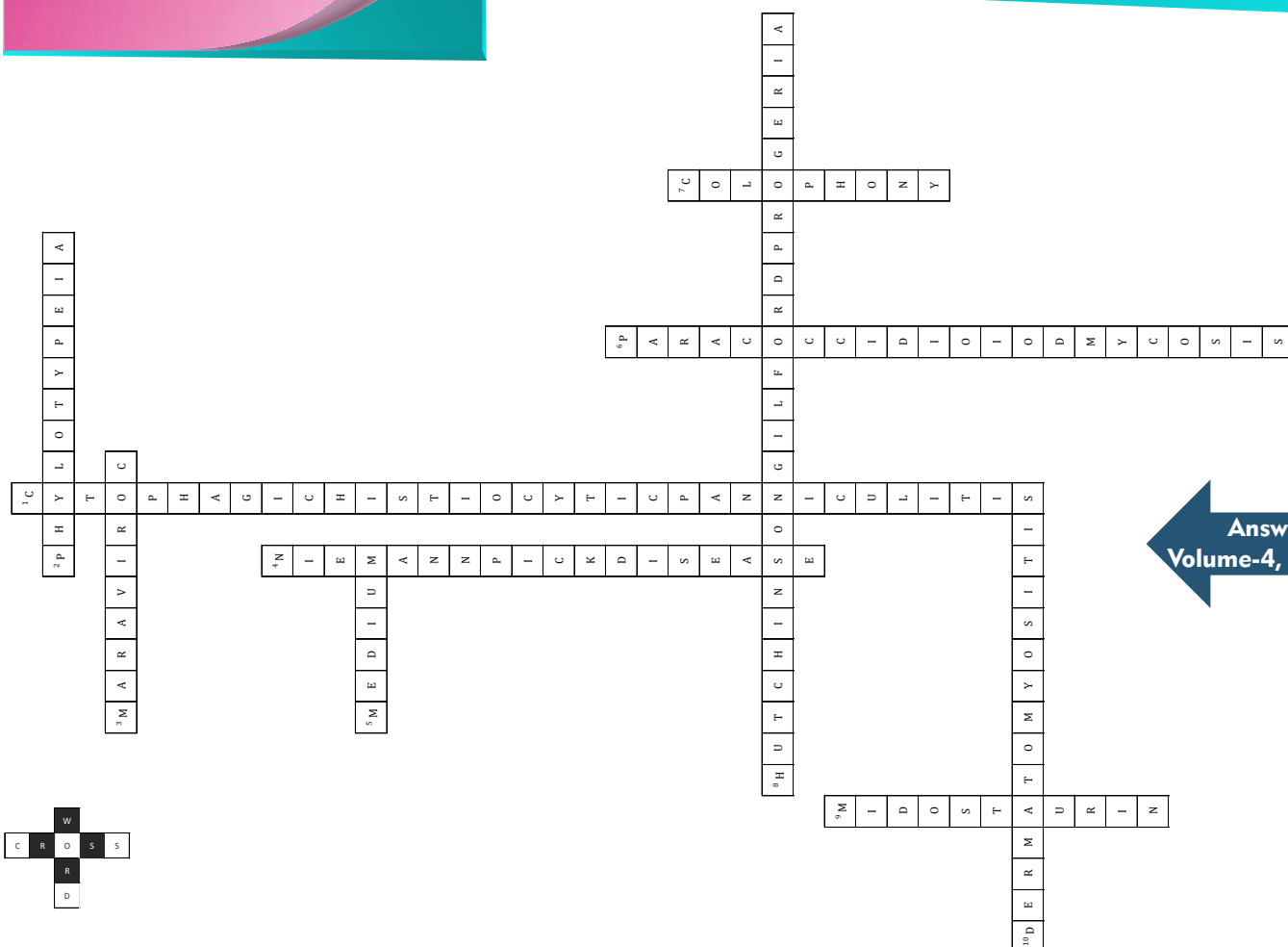
Kindler Syndrome

Dermwiz

I arrive when life has barely begun,
Often where the smallest battles are won.
No bright red warning, no angry flare,
Yet something slowly changes there.

Softness is lost, the body feels bound,
As though winter has entered without a sound.
I spread in silence, firm and deep,
While a fragile little patient struggles to keep.

Some distant corners may escape my hold,
But much of the body turns strangely cold.
I am not merely swelling, nor an infection's hue;
My presence often tells that trouble is not few.



Answer
Volume-4, Issue-6



27th - 29th
November 2026

Venue:
BBCC, New Town,
Kolkata



Theme:
NextGen Dermatology
Clinical Mastery Meets Innovation

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- ① Aesthetic Dermatology
- ② AI in Dermatology
- ③ Allergic Skin Disorders
- ④ Behavioural Patterns in STI
- ⑤ Clinicopathological Correlation
- ⑥ Dermatoeconomics
- ⑦ Dermatology & Internal Medicine
- ⑧ Dermato-Oncology
- ⑨ Emerging Cutaneous Infections
- ⑩ Geriatric Dermatology
- ⑪ Microbiome in Dermatology
- ⑫ Neglected Tropical Diseases
- ⑬ Pediatric Dermatology
- ⑭ Precision Medicine in Dermatology
- ⑮ Psychodermatology
- ⑯ Regenerative Medicine
- ⑰ Robotics in Dermatology
- ⑱ Therapeutic Updates

Program Highlights

OPPORTUNITIES FOR Pgs

Award Paper Session

Quiz

Extempore

e poster



ABSTRACT DEADLINE:
31st October 2026

HANDS-ON LEARNING



Dermatopathology



Procedural Dermatology



AI in Dermatology



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