Newsletter

DermBuzz

INDIAN ASSOCIATION OF DERMATOLOGISTS, VENEREOLOGISTS AND LEPROLOGISTS (DELHI STATE BRANCH)

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Hi Friends,

It's a matter of great joy to release the first Newsletter of 2020. These have been trying times for all of us, something that is experienced once in a century. Our salutations to the healthcare fraternity who is striving very hard to win the battle against the menace of COVID-19. In these difficult times, just as Mother Nature is trying to reset and reboot itself, as if preparing to once again selflessly welcome us humans, the lockdown has managed to rekindle the talent of our DSB members, which has come out by way of this newsletter. Armed with the power of the stylus, our creative minds have put together both dermatology literature and their ingenuity through poetry, cartoons, sketches, crossword and photographs.

We also can not forget the doyens of dermatology from Delhi whom we lost this year, whose immense contributions held our head high.

A big thank you to the editorial team for putting all this together.

I hope you enjoy the first issue of the Newsletter.

Sujay Khandpur

On behalf of IADVL DSB

Aesthetic Medicine: The new frontier for an aspiring Dermatologist

Gone are the days when a person visited a doctor only if he/she had a problem. Today, people are concerned about how they look, how they are perceived by others- and they want to do something about it.

Every face delivers a message. It can be a happy face, a sad face, an angry face and so on. When one looks at another face one can immediately sense if the face is emanating a positive or negative energy. We are subconsciously attracted to a positive, happy face .

Aesthetic medicine is the branch of medicine which deals with enhancing the cosmetic appearance of a particular feature of the body. It has gained prominence in recent times.

This has been due to multiple factors. Firstly, people have an increased spending potential. As the basic needs get fulfilled, one starts looking for other wants that can enrich one's life further. One wants to look more youthful. Easy access to internet has resulted in many youngsters idealizing Bollywood and Hollywood stars. They aspire to look like them. Many of these photographs have been altered with software which gives rise to heightened, unrealistic expectations.

The third change is that people fear undergoing major surgical procedures. They are more comfortable with non-surgical procedures, which also have minimum downtime. Thus, Aesthetic medicine is here to stay, and its reach is going to increase with time.

While Aesthetic medicine is a great opportunity for a physician or a dermatologist, it has its own challenges. Firstly, there is no recognised and verified course for Aesthetics. Most medical colleges in India do not recognise it as a separate clinical entity, and so, doctors have to rely on learning these skills from other practising colleagues. Furthermore, there is no regulation as to who can and cannot practice Aesthetic medicine. As far as the Indian law is concerned any doctor with a BDS or MBBS degree is allowed to practice Aesthetic medicine. This is a great opportunity for dermatologists as they have the basic knowledge to help gain the technical know-how and expertise to guide the patient about aesthetic procedures to enhance their appearance. Often, the changes perceived in 'skin' by the patient are due to loss of volume (subcutaneous) and are easily correctable by these minor procedures such as fillers. This puts us in a unique position where its our specialty that is expected to be able to help these patients. At the same time, however, overlap and competition with plastic surgeons has to be kept in mind. A surgeon may be able to offer additional modalities like facelift, SMAS (submuscular aponeurotic system plication), endoscopic brow lift etc which are outside the scope of a dermatologist, and these may be needed to achieve a particular result, eg, in case of severe eyebags. A dermatologist should be able to recognise these cases and refer to a plastic surgeon. Thus a dermatologist must be very well-trained in the non- surgical and minor surgical procedures to keep up with the competition and carve his/her own niche.

Some of the therapeutic modalities available to a dermatologist are soft tissue fillers, botulinum toxin injections, thread lifts, HIFU (High Intensity Focussed Ultrasound), lipolytic injections, autologous fat injections, and this repertoire is expanding exponentially with newer modalities and less invasive procedures coming up every year.

An intense interest in and a clear knowledge and understanding of regional anatomy is a fundamental prerequisite for learning and practising Aesthetic medicine. Attending hands-on workshops related to all the relevant procedures can be a starting point. Cadaveric workshops can help as well. Joining special interest groups, such as IADVL – SIG Aesthetics is another way to build collaborations and horizontal teaching networks for knowledge-sharing. One should also have a keen interest in current concepts of beauty and aesthetics, as well as good communication with the patient, as the doctor's personal concept of beauty may be different from that of the patient- and it's the latter that has to be taken into account. Different regions have different beauty aspirations. Big eyes may be considered beautiful in one region and not in others, and people often carry these concepts to wherever they migrate to. An ability to build realistic expectations is also imperative, as these patients expect an overnight change aligning exactly with the picture in their mind, and that's nearly impossible to achieve. Thus Aesthetic medicine is a new field of medicine which is still in its infancy in India, and dermatologists have the potential to be the frontrunners in acquiring the skills to practice it so that they can be the leaders, trendsetters and creators of new treatment paradigms in this novel and exciting field.

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Clinical dermatology: the very base of the pizza, if not the whole of it.

Let's start with a case……

A 45-year-old man from Rajasthan received 2 courses of antitubercular therapy for his respiratory complaints in last 18 months with no effect. With prescriptions and papers with all differentials ranging from sarcoidosis to drug resistant TB, he goes from doctor to doctor, undergoing investigation after investigation, each more invasive than the last, none of them giving any positive result. As the disease worsens, it disseminates, showing up on the skin of his face as red papulo-nodules. At the very end of his resolve, he reaches a dermatologist for those lesions and the dermatologist recognizes these papules as Histoplasmosis. A single diagnosis from a handful of lesions, solving the 18-month mystery. This is where the beauty of clinical dermatology lies. In the current era where other disciplines are becoming more and more investigation-dependent each passing day, dermatology holds the baton of clinical medicine high. I don't know if you've noticed but in most clinical disciplines, we don't even look up from the papers to look at the person's face, much less touch him or her- we may place the stethoscope over the lung apices, we might see, but we don't *look*. And among a crowd of such 'clinicians', it's the dermatologist, like Sherlock Holmes with a magnifying lens and torch, deciphering the type of scale and degree of erythema, and sometimes bringing in the microscope because what's more fun than being able to see directly whether the culprits are the Neuts or the Eos and whether the holes they made bled melanin or not? An Eagle's eye-view of the microcosmic world that our skin is, being able to see every little piece of the puzzle.

Even within our specialty, clinical dermatology –once the foundation and large part of the practice- is facing a stern contest to retain its importance and fine skills due to an increased importance of cosmetic dermatology, aesthetics and demato-surgery in practice, especially in the private set-up. This emphasis in practice has spilled over to the training period - I fear that lack of motivation and practice of clinical dermatology in the current generation will make those diagnostic skills to be lost forever. Not everything can be captured in pictures and written down in books, not the delicate arrangement of scales, not the way the light reflects at an angle from some lesions making tangential view the best, not even the exact colour that makes you so sure than you are looking at a lichen aureus lesion. A time will surely come when we will need those skills, but we might realize that we have already lost them- maybe when a loved one has a lesion which could be infective or autoimmune, and our diagnosis will guide the treatment. Or when a patient is at the brink of death, and our incorrect diagnosis of a drug reaction may push him over.

It is important to learn from our great teachers, discuss and read the advancement of clinical dermatology by regularly following journals to keep ourselves updated. It is a science that must continuously be updated- we have seen our teachers often remark at how a case is the first such pattern to that disease that they've seen. The human body has endless possibilities, and disease expression has even more. It's challenging, and exciting, and above all, its fundamental- the very base we stand upon. Many of my colleagues and seniors who are practicing predominantly cosmetic dermatology are of the opinion that clinical dermatology is the most difficult to master- dermatosurgery and aesthetics are rather straightforward. A sound base of clinical dermatology will always come to your rescue in cosmetic practice, because the most essential skill a surgeon must have is not how to hold a scalpel – or in our case, laser handpiece – it is *decision-making.* That skill depends completely, without exception, on your skills of observation, examination, diagnosis. And that, my friends, can only come from a practice, practice and practice of clinical dermatology.

Cosmetology might be the demand of the time, but clinical dermatology is the base on which it stands.

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Pigmented contact dermatitis

(Excerpt from the original article- *Khanna U and Khandpur S. Pigmented contact dermatitis. Pigmentary Disorders. 2015; 2: 214.*)

Pigmented contact dermatitis (PCD) is a non-eczematous variant of contact dermatitis characterized by hyperpigmentation with little or no signs of dermatitis. The term was first used by Osmundsen, a Danish dermatologist, to describe 7 patients who showed a pronounced and bizarre pigmentation secondary to an optical whitener (Tinopal CH3566) used in washing powders.[1] The hue of pigmentation varied between shades of brown and grey, with a reticular pattern in some cases, and was mostly confined to covered sites of the body. The next major series of PCD came to light when 53 workers handling textiles with azo dyes developed PCD demonstrating different morphological patterns like spotted hyperpigmentation, bizarre dark pigmentation, streaky milder pigmentation, mostly confined to the exposed areas.[2]

Aetiology and pathogenesis

The common allergens implicated in PCD are mentioned in Table 1. Commercially available red kumkum (commonly implicated allergen causing PCD in India) contains azo dyes,

coal tar dyes, toluidine red, erythrosine, fragrances, groundnut oil, tragacanth gum, turmeric powder, paraben and cananga oil.

Table 1 :	Common allergens implicated in PCD
Textiles	Naphthol, azo dyes, optical whiteners
Fragrances	Musk ambrette, cananga oil / ylang-ylang oil, benzyl salicylate, sandalwood oil, lavender oil, cinnamic alcohol, jasmine absolute, synthetic sandalwood, sandalwood oil
Cosmetics	Hair dye, lipstick, kumkum, preservatives
Others	Para-tertiary-butyl-phenol formaldehyde (PTBF), wood dust (Plathymenia foliosa), nickel sulphate, chromium hydroxide, cigarette smoke

Osmundsen speculated that PCD reflects idiosyncrasies among patients or mode of exposure to the allergen or a specific peculiarity of the allergen itself.[1] PCD can also develop after exposure to air-borne allergens like cigarette smoke, musk ambrette or Plathymenia foliosa dust. The role of pigment-genetic interaction was considered as most cases of PCD occurred in skin of colour. Some studies demonstrated increase in size, number and enzymatic activity of melanocytes subsequent to cutaneous inflammation. Nagao et al. postulated that the causative allergen may have a special affinity for melanin, inciting an initial inflammatory reaction around the melanocytes which leads to incorporation of melanin granules around the cells.[3]

Clinical features

PCD can occur after 2 months to 2 years of exposure to the allergen necessitating a detailed history to establish the causal relationship.[1,2] Absence of active or preceding dermatitis and/or pruritus makes the diagnosis of PCD difficult.[2] Commonly, reddish-brown to slate grey pigmentation occurs in a reticulate pattern involving the face, lips, axillary borders or thighs.

Clinical variants of PCD

Riehl's melanosis

Riehl first identified this facial pigmentation during World War-I and attributed it to nutritional alteration. The pigmentation was most pronounced over the lateral aspects of face and neck with prominence over the forehead, ears, temple and zygomatic regions. Similar pigmentation was observed during World War II and in malnourished Bantu people of South Africa. Later, Hoffmann and Habermann emphasized the clinical similarities between Riehl's melanosis and 'melanodermatitis toxica', a form of contact dermatitis resulting from use of certain oils and hydrocarbons. Histopathology shows pigment incontinence. Other findings like liquefactive degeneration of basal cells and moderate infiltrate of lymphocytes in the dermis may be subtle.

Pigmented cosmetic contact dermatitis (PCCD)

Minami and Noma described 'melanosis faciei feminae', a pigmented dermatitis in Asian women and attributed it to the use of aniline dyes in cosmetics. Factors differentiating this entity from PCD include involvement of face, cosmetics being the causative agent, preceding or accompanying mild dermatitis in many cases and being more symptomatic. It manifests as diffuse or reticulate, black or dark brown hyperpigmentation of the face with ill-defined margins. It may involve the neck, chest, back or whole body in exceptional cases. Cinnamic alcohol can sensitize the patient to cosmetics leading to extensive PCCD when exposed to soaps, fabric softeners and food containing cinnamic derivatives. Histopathology is similar to PCD, but epidermis may sometimes be atrophic presumably due to frequently applied topical corticosteroids.

Pigmented contact cheilitis

Pigmented contact cheilitis has been described following the use of lipsticks, after exposure to nickel in green tea and para-phenylenediamine in hair dye applied to moustaches.

Purpuric dermatitis

This variant was observed during World War II in British soldiers who sweated profusely or experienced friction due to their khaki shirts, woollen socks and elastics in undergarments. Allergens including N-phenyl-N'-isopropyl p-phenylenediamine (IPPD), N-phenyl-β-naphthylamine (PNA), 2-mercaptobenzothiazole (MBT), dibenzothiazole disulphide (DBD), textile finishes and dyes were implicated.

Differential diagnosis

Inflammatory processes like lichen planus, lichenoid drug eruption and fixed drug eruption, which disturb the dermo-epidermal junction causing melanin to pass into the upper dermis may produce persistent pigmentation.[1] Though uncommon, hyperpigmentation may occur in the course of irritant and allergic contact dermatitis.[1] A close clinical differential, lichen planus pigmentosus (LPP) presents with generally asymptomatic dark-brown to slate-grey macules mostly over the exposed areas and flexures distributed in a diffuse, reticular, blotchy or perifollicular pattern. Another differential, melasma is characterised by symmetrical brown to grey-brown macules distributed in a blotchy/irregular/arcuate/polycylic pattern over sun-exposed areas. Frictional melanosis manifests as dark brown to black hyperpigmentation over bony prominences. Other differential diagnoses include amyloidosis cutis and atopic dermatitis with pigmentation. In a study evaluating 43 Thai patients (skin types IV-VI) with erythema dyschromicans perstans (EDP), LPP and PCD, histopathology showed melanin incontinence in almost all cases, with

pronounced lichenoid inflammatory reaction in EDP and LPP, and liquefactive degeneration of basal layer in PCD[4] In the same study, while 80% of PCD cases showed patch test positivity, 40% of EDP cases and 36.3% of LPP cases also showed a positive patch test result.[4] Thus histopathology or patch test alone may not help in differentiating PCD from its close mimickers.

Investigations

Closed patch testing should be carried out using the standard, cosmetic, fragrance series and patients' personal products along with a photo patch test. Besides a papule or vesicle, brown to bluish-brown pigment may also be seen at the site of patch test. In cases with equivocal closed patch test results, the provocative usage test (PUT) or repeated open application test (ROAT) may be used to identify a reaction.

Prevention and treatment

It is important to avoid using textiles and washing powders that contain potent contact sensitizers and use allergen-free soaps. In many instances the impurities in the colouring dyes are primary cause of PCD. New textile finishes introduced in the market should be subjected to minimum safety evaluation tests (LD50, Ames test, skin irritation tests, sensitising potential of chemicals test). Allergen controlled apparel similar to allergen controlled cosmetics were introduced in Japan to counteract PCD. Pigmentation in PCD tends to persist for years even after withdrawal of the implicated allergen.

Conclusion

PCD is a distressing condition, posing a diagnostic challenge. Patch and photopatch testing is important to identify the implicated allergen and establish the diagnosis. Histopathology results are frequently inconclusive. Avoidance of subsequent exposure to the allergen forms the mainstay of treatment.

References

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4. Tienthavorn T, Tresukosol P, Sudtikoonaseth P. Patch testing and histopathology in Thai patients with hyperpigmentation due to Erythema dyschromicum perstans, Lichen planus pigmentosus, and pigmented contact dermatitis. Asian Pac J Allergy Immunol 2014; 2: 185-92.

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Interesting work in recent times

We recognize that in today's day and age of rapid scientific progress, one needs to stay updated. We bring to you the abstracts and our take on selected recent work.

1. Effect of Sunscreen Application on Plasma Concentration of Sunscreen Active Ingredients: A Randomized Clinical Trial. Matta MK, Florian J, Zusterzeel R, et al. JAMA Dermatol. 2020; 323: 256-67.

Background: Sunscreen is an important adjunct in prevention of solar skin damage and skin cancer.

Aim: To assess the systemic absorption and pharmacokinetics of 6 active ingredients (avobenzone, oxybenzone, octocrylene, homosalate, octisalate, and octinoxate) in 4 sunscreen formulations under single- and maximal-use conditions.

Materials and Methods: A total of 48 healthy volunteers were randomized to receive one of the 4 sunscreen formulations (lotion, aerosol spray, non-aerosol spray, pump spray) in indoor setting (pharmacology unit). They applied sunscreen once a day on D1, every 2 hourly for D 2-4 over 75% body surface area at 2mg/m^2. Plasma concentration of each ingredient was measured on D 1-4, 5, 6, 7, 10, 14 and 21.

Results: Majority were young adults (mean age 38.7 years) with Fitzpatrick skin types II (19%), III (63%), IV (19%). On evaluation, mean geometric plasma concentration of all 6 ingredients was found to be more than 0.5 ng/mL (upper limit set by US FDA) amongst all 4 groups. Highest levels were of oxybenzone (180-258 ng/mL) followed by homosalate (13.9-23.1 ng/mL). Interestingly, this threshold was crossed on day 1 itself after single application of sunscreen. In addition, many participants had concentrations above threshold level up to day 21.

Conclusion: This study discusses potential for dangerous effects of prolonged sunscreen use.

Our take: A well-conducted study with adequate sample size, however, real life conditions were not simulated. Relevance of these results also needs validation in darker skin types. Physical sunscreens might have better safety profile.

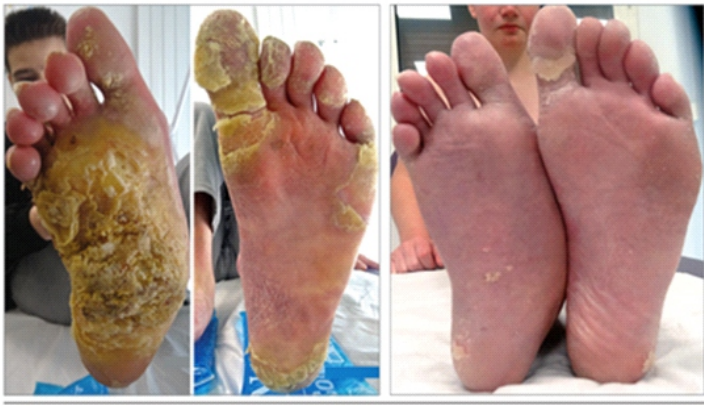
2. Use of Epidermal Growth Factor Receptor Inhibitor Erlotinib to Treat Palmoplantar Keratoderma in Patients With Olmsted Syndrome Caused by TRPV3 Mutations. Greco C, Leclerc-Mercier S, Chaumon S, et al. JAMA Dermatol. 2020. doi:10.1001/jamadermatol.2019.4126. [Epub ahead of print]

Background: Olmsted syndrome is a hereditary palmo-plantar keratoderma (PPK) associated with severe pain and debilitation. Most cases are due to mutation in transient receptor potential vanilloid 3 (TRPV3), constitutive activation of which leads to trans-activation of epidermal growth factor receptor (EGFR) signaling, leading to altered keratinocyte proliferation and differentiation.

Aim: To examine the possibility of blocking EGFR transactivation with the inhibitor erlotinib hydrochloride (EGRF inhibitor) to treat PPK in Olmsted syndrome.

Materials and Methods: 3 patients from 2 unrelated families(2 boys, one girl) who had TRPV3-mutation–associated PPK were treated with erlotinib, at 50 to 125 mg/day (started at 70mg/m^2/day), much lower than chemotherapeutic dose.

Results: In all 3 cases, the severe pain resolved by 1 month and hyperkeratosis of palmo-plantar skin by 3 months. Insomnia, anorexia, delayed growth and puberty, poor quality of life improved considerably. The therapy was continued till one year at lowest possible doses with maintenance of remission. Adverse effects noted were hair loss, acneiform eruption, abdominal pain, nausea and desquamation at fingers and toes.



Our take: This small case series has given a promising therapeutic intervention, alongwith discussing the pathomechanism. Long term, large scale studies are needed to confirm the findings.

3. Crisaborole 2% ointment for the treatment of intertriginous, anogenital, and facial psoriasis: a double-blind, randomized, vehicle-controlled trial. Hashim PW, Chima M, Kim HJ. J Am Acad Dermatol. 2020; 82: 360-65.

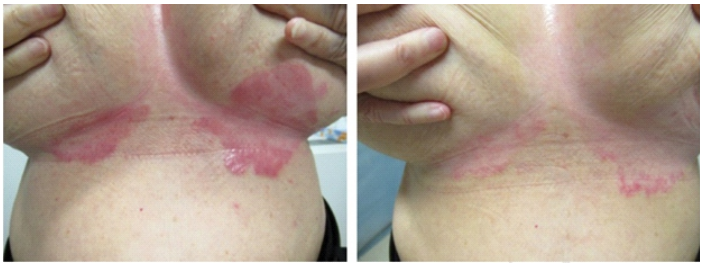
Background : Thin-skinned areas and occluded skin folds are particularly sensitive to adverse effects of corticosteroids. Crisaborole, a topical phosphodiesterase-4 inhibitor already approved for use in atopic dermatitis has anti-inflammatory properties and lacks associated skin atrophy.

Aim: To assess the efficacy and safety of crisaborole 2% ointment in treatment of facial, anogenital, and intertriginous psoriasis.

Materials and Methods: 14 cases and 7 controls received twice-daily application of either crisaborole 2% ointment or placebo respectively for 4 weeks followed by open label application of crisaborole 2% ointment in both groups for next 4 weeks.

Results: Crisaborole arm showed 66% improvement compared to 9% in the placebo group (p=0.0011) at the end of 4 weeks. Patients in crisaborole arm continued to show further improvement (81%) on further treatment, with 71% of these cases showing complete clearance. No adverse effects were noted.

Our take: A newer topical agent has been added to the armamentarium of agents against psoriasis, Further large scale studies with longer follow up are needed. Availability and cost need to be considered.



4. The Clinical Utility of Laboratory Monitoring During Isotretinoin Therapy for Acne and Changes to Monitoring Practices Over Time. Barbieri JS, Shin DB, Wang S, et al. J Am Acad Dermatol. 2019; 82: 72-9.

Background: Isotretinoin is frequently used in management of acne, often with frequent monitoring of laboratory parameters. Clinical utility of such monitoring is questionable.

Aim: To evaluate the frequency of laboratory abnormalities in patients on isotretinoin.

Materials and Methods: Clinical and laboratory monitoring details of 1863 patients was studied using electronic database.

Results: Grade 3 or greater triglyceride and liver function test abnormalities were found in 1% and 0.5% cases respectively. In most cases, elevated levels did not lead to discontinuation of isotretinoin therapy. Abnormalities were noted either at baseline or within 2-3 months of therapy. Cholesterol levels ≥ grade 3 or hematological derangements were not found.

Our Take: The study emphasizes on reducing the laboratory monitoring, which would lead to cost reduction and reduced physical discomfort to patients.

5. A retrospective case series of 12 patients with chronic reactive arthritis with emphasis on treatment outcome with biologics. Gupta V, Mohta P, Sharma VK, Khanna N. Indian J Dermatol Venereol Leprol. 2019. doi:10.4103/ijdvl.IJDVL_519_18. [Epub ahead of print]

Background: A small percentage of patients of chronic reactive arthritis develop severe recalcitrant disease. Information in literature on management of recalcitrant disease is insufficient.

Aim: To review the clinical features and management of patients with chronic reactive arthritis admitted to the dermatology department of a teaching hospital.

Materials and Methods : Retrospective analysis of patients with reactive arthritis admitted for in-patient management to a tertiary care hospital in Delhi over two years (2016-2018).

Results: 12 male patients were included. Duration of disease ranged from 9–180 months. Biologics were used in 9 (75%) patients on 16 different occasions, the most frequent being infliximab (n = 10), followed by adalimumab (n = 3), etanercept, secukinumab and itolizumab (n = 1 each), in combination with other systemic agents. Response rate with treatment regimens including biologics was statistically significantly better than those without biologics. Biologics were discontinued on 50% of the occasions, after a median of 3.5 months (range 1.5–7.5months). After biologic discontinuation, the response was sustained for a median of 5 months (range 3–6 months) before disease exacerbation. The number of treatment switches increased with the follow-up duration.

Conclusion: Biologics produce rapid improvement in skin and joint symptoms in chronic reactive arthritis, but the response is not long-lasting. Patients with chronic reactive arthritis have a waxing and waning course despite regular treatment.

Our Take: Management of severe chronic reactive arthritis is challenging. In this retrospective study with a small sample size, most of the patients were on conventional agents while biologics were administered, limiting the conclusions drawn on efficacy of biological agents. However, there is lack of information in literature about indications of and response to biologics in severe reactive arthritis, especially with an emphasis on skin manifestations.

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Helen Ollendorff-Curth: A dedicated researcher and academician

Helen Ollendorff-Curth was one of the first women to contribute extensively to the field of Dermatology as an academician and researcher. Her various research contributions continue to be widely used and studied even today.

She was born in a Jewish family in Breslau, Germany, and studied medicine at several prestigious German universities, rotating in Breslau, Freiburg, and Munich. It was at Breslau where she made her first and perhaps most important contribution to the field of Venerology as a part of her medical school thesis. She observed and hence described the **Ollendorff probe sign**, which refers to the exquisite tenderness of the papules of secondary syphilis, especially those seen on the palms and soles, when touched gently with an examination probe.

She studied with Professor Abraham Buschke in Berlin from 1924 onwards with whom she described the oft-used eponym **Buschke–Ollendorff syndrome**, which refers to disseminated dermatofibrosis, a rare autosomal dominant disorder which may be associated with osteopoikilosis. It was also in Berlin that she met and married a fellow dermatologist, Wilhelm Curth and together moved to Columbia, USA, forced to emigrate due to growing anti-Jewish sentiments.

She widely lectured on acanthosis nigricans and other cutaneous signs of internal malignancy and went on to publish **Curth's criteria** for the diagnosis of paraneoplastic acanthosis nigricans. Her last but definitely not the least contribution was her description of the **Curth–Macklin ichthyosis** with Madge Macklin. This rare genodermatosis presents as hyperkeratotic plaques that may coalesce over flexors and extensors causing painful, bleeding fissures.

Helen Ollendorff-Curth continued to work as a dedicated dermatologist,both a great clinician and academician till she developed dementia and passed away at the age of 83 years.

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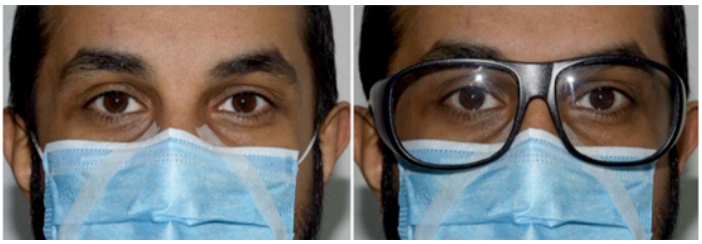
Surgical Pearls: Simple solutions to common problems

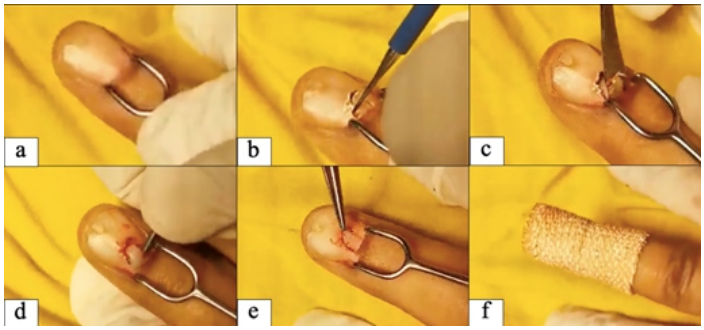
#1: Spectacles have become ubiquitous. Eye protection in the form of glasses is also imperative for laser procedures, and is recommended as a part of universal precautions as well. However, add to it a mask and an air-conditioned OT, and we get progressive fogging, reducing visibility quite sharply. An easy way out is to use strips of paper tape to occlude the gap between the mask and cheek, reducing the amount of air gushing up onto the glasses. Try it out!

AlJasser MI. A simple method to prevent fogging of goggles during laser procedures. J Am Acad Dermatol. 2020; 82: e125.



#2: Nail plate needs to be removed for Glomus tumor excision- and such removal, whether partial or complete, when extending to the matricial attachments, results in a small chance of matrix damage and resultant distortion of the new nail plate. This also requires lifting of a flap of proximal nail fold to access the tumor. But what if we could remove only a piece of nail plate covering the tumor? This may be done by mere retraction of the proximal nail fold, without raising a flap. The procedure demonstrated by the authors can definitely be tried for smaller tumors.

Bhatia S, Chauhan J, Grover C, et al. Radio-frequency assisted 'onychostomy' for minimally-invasive extraction of subungual tumors. J Am Acad Dermatol. 2020 April 19. doi:https://doi.org/10.1016/j.jaad.2020.04.055.
[Epub ahead of print]



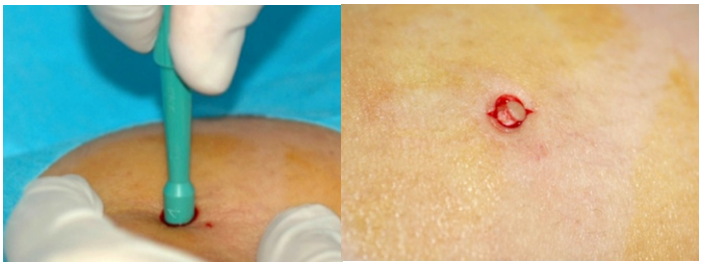
#3 : Use of OHP sheet for face shield during dermabrasion: Mechanical dermabrasion, especially when done by motorized burr, results in aerosolisation of tissue material, including blood. This simple and inexpensive material can be easily modified to make a durable single-use shield. One method links it with a surgical mask, while another makes it into a head-mounted shield. Video available at

https://m.facebook.com/story.php?story_fbid=10157634893264652&id=584534651?sfnsn=scwspwa&d=w&vh=i&extid=LhOMfyE62LW1lxpc&d=w&vh=i

(Courtesy: Dr Thichen K Lama)

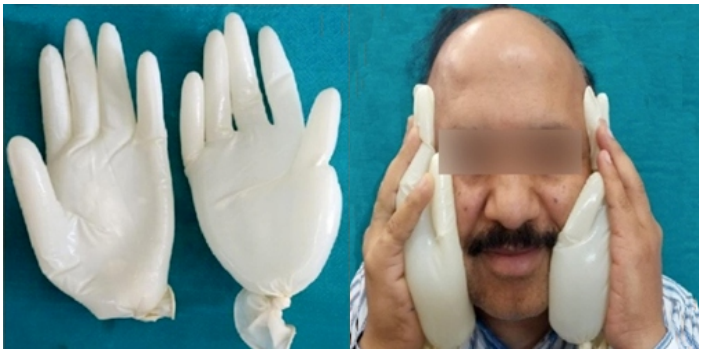
#4 : Use of a simple modification for punch biopsy in suspected panniculitis. Incisional biopsy might be difficult to perform, and the two-punch technique relied on removal of the epidermis and dermis. What if the same punch could be introduced all the way in deep, giving us a neat cylinder to interpret? It's a three step process. Use the punch to cut through the epidermis and dermis, and remove the punch while leaving core tissue in-situ. Thereafter, application of two small relaxing incisions on either side of the initial punch allows repositioning of the same punch, along with further deeper advancement to reveal a single cylinder of tissue including the panniculus.

Ersoy-Evans, S. Surgical pearl: A novel punch biopsy technique for diagnosing panniculitis. J Am Acad Dermatol. 2015; 72: e161-2.



#5 : Cryoanesthesia using a surgical glove filled with refrigerant jelly. Use of a sterile glove filled with the malleable and quick-cooling refrigerant jelly allows for customized shaping of the anesthetizing material and reuse of the jelly material. Can be readily used as they are shaped as the human hand and may be comforting for children.

Gupta S, Jangra RS, Gupta S, et al. Surgical glove filled with refrigerant jelly for cryoanesthesia. J Am Acad Dermatol. 2019 July 19.
doi: https:// doi.org/10.1016/j.jaad.2019.05.108.
[Epub ahead of print]



#6: Perception drift. In today's age of easy access to cosmetic enhancement procedures, with patient's perception being the absolutely subjective scale of measurement, it is important to recognize and subvert this very real phenomenon. One needs to recognize that the patient's definition of beauty as well as perception of self will change, in addition to increased focus on smaller blemishes not previously focused on. A perpetually dissatisfied patient may just be exhibiting this phenomenon, which can be managed and prevented by proper photographic documentation and periodic review by the patient him/herself. It is a normal, slow change of perception of one's appearance and preferences, which may occur over periods as short as 2 weeks

Sola CA, Fabi SG. Perception Drift. Dermatol Surg. 2019; 45: 1747-8.

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Mediators of pruritus: ITCH-O-PINS

Interleukin-31
Tryptase
Cathepsin S
Histamine
Opioid (mu) receptor agonists
Prostaglandin E2
Interleukin-2
Nerve growth factor
Substance P

Courtesy: Dr Ananya

Painful cutaneous nodules: BENGAL DOCS

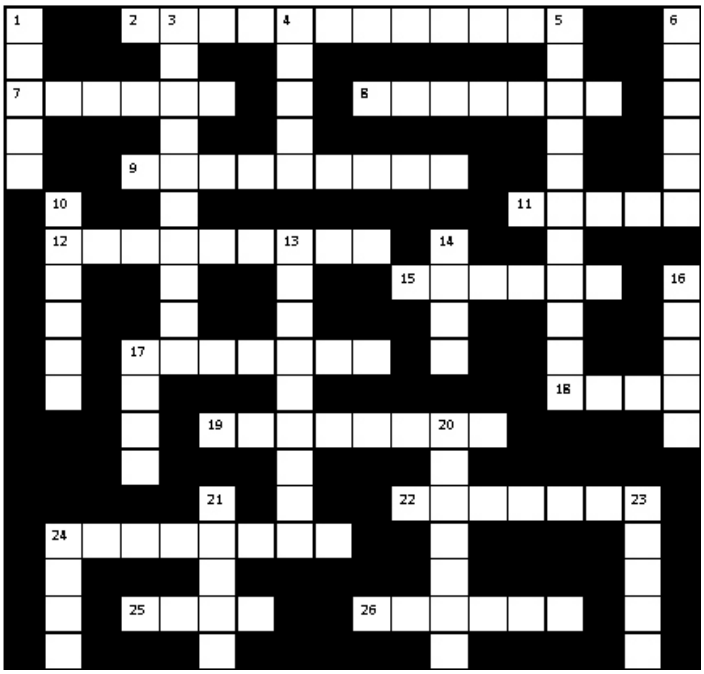
Blue rubber nevus
Eccrine spiradenoma, **E**rythema Nodosum
Neurilemmoma, **N**euroma
Glomus tumor, **G**ranular cell tumour
Angiolipoma, **A**ngioleiomyolipoma, **A**ngiosarcoma, **A**rthropod bite
Leiomyoma

Courtesy: Dr Ananya

Dercum's disease, **D**ermatofibroma
Osler's node, **O**steoma cutis
Calcinosis cutis, **C**utaneous endometriosis
Sweet syndrome

Courtesy: Dr Nick R. Love, Stanford school of Medicine

CRUCIVERBA



ACROSS:

2. Michaelis-Gutmann bodies are a pathognomonic feature of this disease
7. Structure derived from Sucquet Hoyer canals
8. Hemangioma presenting as a small violaceous papule surrounded by a pale, thin area and a peripheral ecchymotic ring
9. Law stating that, if a woman with untreated syphilis has series of pregnancies, the likelihood of infection of the fetus in later pregnancies becomes less
11. Disease characterised by presence of knife-cut ulcers in the groin
12. Drug which is effective for treatment of palmoplantar keratoderma in patients with Olmsted syndrome caused by TRPV3 mutations
15. Classified nevus fuscoceruleusopthalmomaxillaris
17. Criteria for the diagnosis of malignant syphilis
18. Hyperostosis of soft tissues surrounding joints of spine secondary to retinoids
19. Syndrome of acquired cutis laxa characterised by post-inflammatory elastolysis and without any systemic involvement
22. Association of erythema nodosum with bilateral hilar and right paratracheal-adenopathies, with or without pulmonary infiltrates

24. Presence of "Bird-like" facies and "Mickey mouse" appearance
25. Familial leiomyomatosis cutis et uteri
26. Cytokeratin-20 is a specific marker for this cell

DOWN :

1. Vasculopathy affecting medium and small veins and arteries, complicated by intestinal perforation and treated with a C5 blocker
3. Newly proposed species of Malassezia from PGIMER, India and closely related to M.restricta
4. Heat-associated squamous cell carcinoma of Japan
5. Stains calcium
6. Cell with high lipid content and wreath of nuclei
10. Syndrome associated with large perineal hemangiomas
13. Hereditary ichthyosiform disease caused by mutation in SPINK5
14. Autosomal dominant condition with lentigines, myxomas of heart and skin and blue nevi
16. Variant of erythema multiforme major with exclusive mucosal involvement
17. This supplementary cytogenetic test can be used to differentiate melanoma from melanocytic nevi
20. Noonan syndrome with multiple lentigines
21. Cytokeratin 7, anticytokeratin (CAM 5.2), gross cystic disease fluid protein-15 are used as markers for this disease
23. Preferred laser for pigmented lesions
24. Brooke-Spiegler syndrome is caused by mutations within this gene

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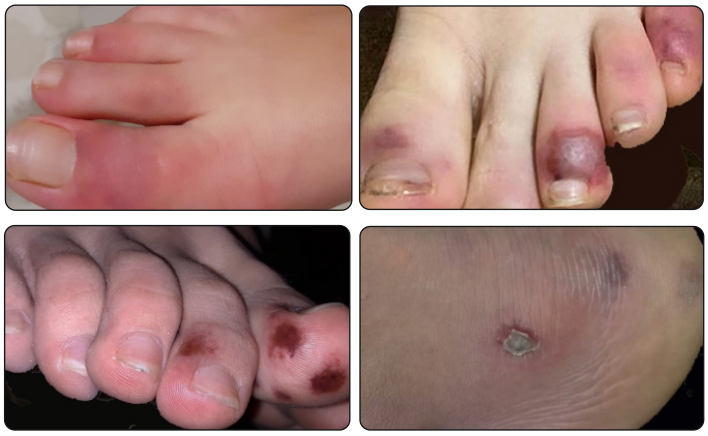
Cutaneous manifestations in COVID-19

As we know, the recent SARS-CoV-2 pandemic that has raged the world predominantly presents with URTI symptoms including dry cough, fever and malaise. However, a preliminary data of cutaneous manifestations noted by dermatologists involved in front line management of COVID positive patients at the Alessandro Manzoni Hospital, Lecco, Italy, revealed that of 88 patients, 18 (20.4%) had skin involvement, which included erythematous rash (14/18, 77.7%), widespread urticaria (3/18, 16.66%) and chickenpox-like vesicles (1/18, 5.55%).[1] Eight of these 18 patients (44.4%) had cutaneous lesions at onset of symptoms whereas the rest developed them after hospitalization. Lesions were minimally pruritic and usually resolved in a few days. Trunk was the main site of involvement. There was no apparent correlation with severity of disease. The skin manifestations were deemed similar to cutaneous involvement occurring during common viral infections. This was a significantly higher percentage than what was seen in the review of 1099 cases of COVID-19 infection studied by Guan et al. in mainland China, which mentioned that only 0.2% patients had a 'rash'.[2] There have also been reports of acute, self-healing acro-ischemic lesions in children and adolescents, involving commonly the lower limb digits as well as plantar surfaces in the form of painful, reddish purple or bluish papules with or without crusts and bullae- postulated to be a manifestation of secondary microthrombosis due to endothelial damage.[3] This presentation preceded the development of classical COVID respiratory symptoms by 2 days in a report.[3] Another report from Thailand by Joob B et al. described presentation of COVID-19 with petechial rash and low platelet count, mistakenly diagnosed as dengue.[4] A high degree of suspicion with regard to viral exanthem-like lesions in the current scenario would be prudent.



References:

1. Recalcati S. Cutaneous manifestations in COVID-19: a first perspective. J Eur Acad Dermatol Venereol. 2020 Mar 26. doi: 10.1111/jdv.16387. [Epub ahead of print].
2. Guan WJ, Ni ZY, Hu Y et al; China Medical Treatment Expert Group for Covid-19. Clinical Characteristics of Coronavirus Disease 2019 in China. N Engl J Med. 2020 Feb 28. doi: 10.1056/NEJMoa2002032. [Epub ahead of print].
3. Mazzotta F., Troccoli T. Acute acro-ischemia in the child at the time of COVID-19. Dermatologia Pediatrica. 2020 March. Available from: https://img.beteve.cat/wp-content/uploads/2020/04/acroischemia-ENG.pdf
4. Joob B, Wiwanitkit V. COVID-19 can present with a rash and be mistaken for dengue. J Am Acad Dermatol. 2020; 82: e177.

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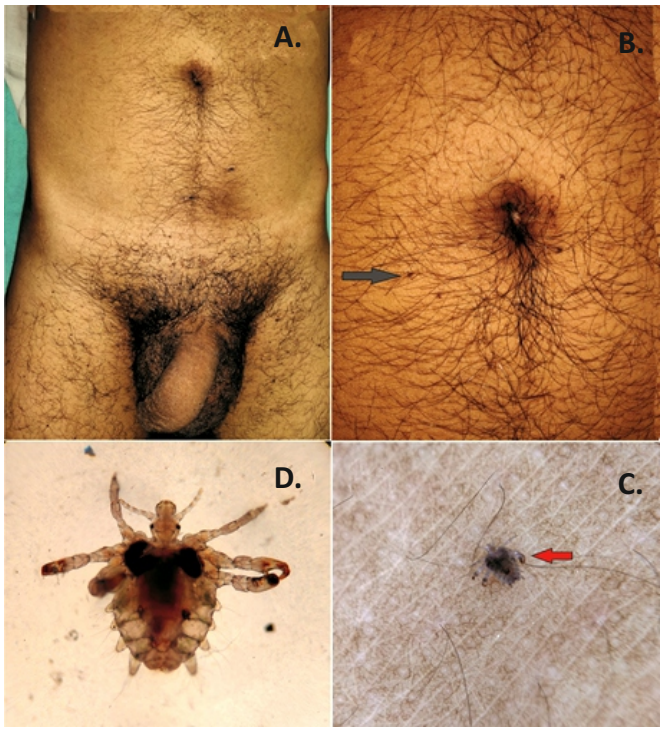
Severely itchy, tiny grey dots

A 33 year-old married man presented with complaints of itching over genitalia, axillae and abdomen for past 2 months. Itching started over genitalia and gradually spread cranially up to axillae. Simultaneously, he noticed multiple black dots over the involved sites (Fig. a-b). These dots could not be easily removed by gentle rubbing or scratching. The patient denied history of high risk behaviour. There was no history of similar complaints in the spouse. On clinical examination, multiple grey black pinhead sized dots were present in groups over the axilla, groins and periumbilical region, without any signs of inflammation, mimicking dermatitis neglecta. A dermatoscopic (10X, DL3N) examination showed pale grey-colored louse grasping the body hair with claws (Fig. c). A live louse was extracted and examined under the microscope which showed adult pubic louse with six legs (Fig. d). The posterior legs were modified into thick claws that help the lice in embracing the hair to maintain a firm grip.



Diagnosis: Phthirus pubis

Discussion:

Pubic louse (Phthirus pubis) is an uncommon body infestation that is commonly acquired sexually and rarely by contact with objects. It affects the genitals while other sites like axilla, abdomen, thigh, chest, beard or eyelashes may also be involved (apocrine rich areas).[1] The lice feed on host blood for survival. Usually patient complaints of itching over the genitals but may present as light blue macules ('maculae cerulae') or erythematous papules over the bite sites.[2] Parasite can be seen with naked eyes using either a hand lens or a dermatoscope. In addition, higher magnification of dermatoscope aids in differentiating the nymphs and empty cases.[3]

Once diagnosed, all patients with pubic lice should be examined and investigated to rule out other sexually transmitted disease as risk of their co-existence is approximately 30%.[4] Treatment involves maintaining hygiene along with permethrin 1% cream application for 10 mins. Other options include oral ivermectin (250 µg/kg dose, repeated over a week), malathion (0.5% lotion for 12 hours), phenothrin (0.2% lotion for 2 hours) and benzyl benzoate 25% lotion.[2]

All the sexual partners should also be screened for active infection.

References:

1. Marwah M, Gautam M, Patil S, et al. Migratory "moles"-dermoscopic diagnosis. Indian J Dermatol Venerol Leprol. 2012; 78: 665.
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3. Chuh A, Lee A, Wong W, et al. Diagnosis of pediculosis pubis: A novel application of digital epiluminescence dermatoscopy. J Eur Acad Dermatol Venereol. 2007; 21: 837-8.
4. Ko CJ, Elston DM. Pediculosis. J Am Acad Dermatol. 2004; 50: 1–12.

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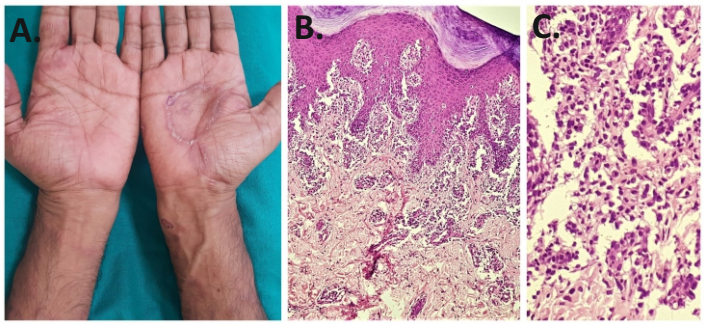
Plasmacytic circles on the palm!



A 47-year-old heterosexual man presented with multiple asymptomatic erythematous annular plaques on the hands and feet for 2 months. He also complained of significant weight loss in the past few months. He had a history of unprotected sexual contact with a female sex worker 6 months back. The patient reported no history of genital ulceration, fever or systemic symptoms. Physical examination revealed multiple well-defined, erythematous, infiltrated annular plaques ranging in size from 3 x 3 cm to 6

x 6 cm with fine semi-adherent white scales on the borders, present over dorsal and palmar surfaces of the hands, right wrist, (Figure A) and soles. Lymph nodes were not palpable. Scalp, mucosa and nails were not involved. Systemic examination was unremarkable. Skin biopsy from the palm revealed hyperkeratosis and irregular acanthosis. Superficial and mid-dermis showed dense perivascular and interstitial infiltrate of lymphocytes, histiocytes and plasma cells (Figure B, C). Rapid plasma reagin test was reactive at a titer of 1:64. Treponema pallidum hemagglutination assay and human immunodeficiency virus (HIV) serology were positive. Routine blood investigations were within normal limits. On the basis of history, examination, histopathologic and serologic findings, a diagnosis of secondary syphilis with HIV was made. The patient was treated with a single dose of injection benzathine penicillin 2.4 million units by intramuscular route, following which the lesions cleared completely in 4 weeks.

Diagnosis: Annular secondary syphilis

Discussion:

Syphilis has been regarded as a great imitator due to its varied clinical presentations. The most common cutaneous manifestation in secondary syphilis is generalized coppery-colored maculopapular rash. Uncommon variants include annular, lichenoid, pustular, nodular and corymbose type of lesions. Patients with syphilis and HIV co-infection are likely to have atypical presentations. Annular plaques have been reported to occur on the face, neck, penis and scrotum and are more commonly described in black individuals.[1-3] Differential diagnoses to be considered for annular lesions are granuloma annulare, sarcoidosis, tinea, leprosy and erythema annulare centrifugum. A high index of clinical suspicion for syphilis, followed by serologic testing and histopathological examination are crucial for accurate diagnosis and prompt treatment.

References

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2. Ma DL, Vano-Galvan S. Annular secondary syphilis. N Engl J Med. 2014; 371: 2017
3. Narang T, De D, Dogra S, et al. Secondary syphilis presenting as annular lichenoid plaques on the scrotum. J Cutan Med Surg 2008; 12: 114-6.

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Back to Basics: Condy's compresses and bath

Pemphigus patients are a group commonly treated by the medical dermatologist. One of the important aspect of management of pemphigus is care of the erosions, including cleansing, medication/emollient application, and non-adherent dressing.

According to British Association of Dermatologists (BAD) guidelines for pemphigus, potassium permanganate soaks (1:10000) dilution can be used for wet erosions. It has disinfectant, deodorizing and astringent properties, in addition to anti-inflammatory and antipruritic effects.[1] This dilution may be achieved by adding 400mg (1 tablet) of $KMnO_4$ to 4 litres of water or 1-2 specks of crystal to 2 litres of water, attempting for a 1:10000 concentration. Patients are usually advised to dilute till the colour is light pink matching a normal healthy nail bed. This solution should be made in hot water, initially, and only after straining through a gauze to ensure no intact crystals are left, it should be added to bath water to achieve the desired concentration. This solution should be allowed to be in contact with skin for 15 minutes, as it gets oxidized after that and is rendered ineffective. We usually use this as soaked dressing pads or gauze swabs, especially to hasten the removal of crusts over pemphigus lesions.[2] The guidelines, however, mention that soaking in a bath is the most effective way to do this! We tried this in a young patient with body surface area nearly 50% who was unable to cooperate with the soaked pads, and he actually enjoyed soaking in the bath, leading to rapid removal of thick crusts.

Named after a chemist Henry Bollman Condy who patented and subsequently manufactured it (no conflicts of interests there!), Condy's solution came to be known as a disinfectant with many uses.

- Washing of clothes of patients with infectious diseases
- Sterilization of instruments (1:1000)
- Irrigation of wounds (1:4000)
- Gargles (1:5000)
- 0.5% solution for gastric lavage in suspected poisoning
- Crystals were directly used for local treatment of snake bites, as it may oxidize the poison, however, this is no longer recommended.

Other dermatological diseases where Condy's soaks and baths may be used as part of the supportive treatment include

- Eczema with or without secondary infection in children: suggested bathing time is 5 minutes for babies and 15 minutes for older children

- Irrigation and cleaning of ulcers, especially diabetic foot[3]
- Fungal infections, especially Tinea pedis - 1:100 dilution may be used
- Pustular psoriasis[4]
- Impetigo

Like we mentioned, most guidelines recommended soaking in these baths, not merely washing with it (although that helps too). For children, and for limb lesions in adults, immersion is practical even in our setting, and may be tried.

Reference :

1. Harman KE, Brown D, Exton LS, et al. British Association of Dermatologists' guidelines for the management of pemphigus vulgaris 2017. Br J Dermatol. 2017; 177: 1170-1201.
2. NHS Patient information leaflet. From: imperial.patient.information@nhs.net.
3. Delgado-Enciso I, Madrigal-Perez VM, Lara-Esqueda A, et al. Topical 5% potassium permanganate solution accelerates the healing process in chronic diabetic foot ulcers. Biomed Rep. 2018; 8: 156–9.
4. Pavithran K. Psoriasis: Topical treatment. Indian J Dermatol Venereol Leprol. 2001; 67: 85.

Child is comfortable while staying submerged in warm water with $KMNO_4$ for 10-15 minutes. He was encouraged to remove the crusts himself.

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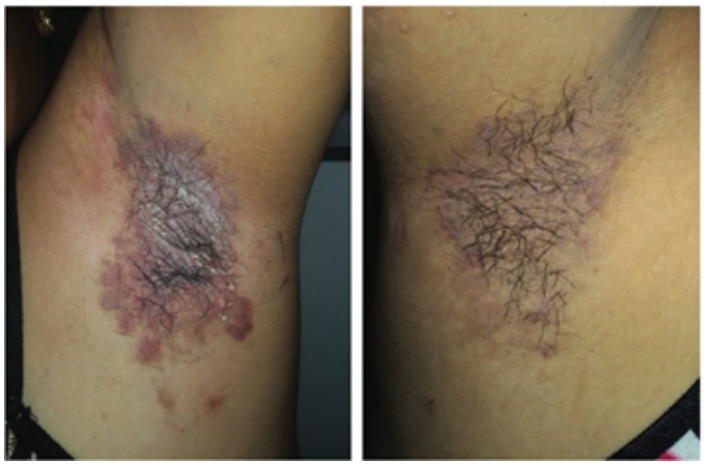
Use of Magnesium Chloride in Hailey-Hailey Disease

A 72-year-old woman, frustrated with suffering from Hailey-Hailey disease (HHD) involving the vulva and inguinal folds for over 45 years, did not have much improvement with a multitude of treatments. Frequent exacerbations complicated her chronic illness. She thereafter developed diffuse joint pain, and self-treated it with oral magnesium chloride solution on a friend's suggestion. She took 70 mL of the solution daily after breakfast (corresponding to 33 mg of elemental magnesium). Unexpectedly after one week, her skin lesions improved and complete remission was obtained in four weeks. At three months, complete re-epithelialization of all the skin lesions was seen.[1] This serendipity has been replicated in four cases so far in literature, with all four reporting unexpected and persistent improvement in symptoms of HHD within 2-3 weeks of starting the consumption of oral magnesium chloride solution. One of the patients had consumed magnesium citrate solution and high dose vitamin D. No side effects have been reported in these cases.[2,3]



Erythematous, macerated and scaly plaque in axilla cleared after 1 month of therapy with oral $MgCl_2$

From: Barde NG, Mishra DB, Ingole SO. Oral magnesium chloride: A novel approach in the management of Hailey–Hailey disease. Indian J Dermatol Venereol Leprol. 2017; 83: 259-62

HHD occurs due to mutation in the ATP2C1 gene, encoding for the Ca^{2+}/Mn^{2+}ATPase protein 1. This protein transports and increases concentration of calcium inside the Golgi apparatus. A deficiency in the intracellular calcium stores results in production of defective desmosomal proteins thus predisposing to acantholysis. Magnesium ions lead to indirect increase in intracellular calcium concentration by inhibiting the cell membrane Ca2+ATPase efflux pump, and hence restore the calcium homeostasis.[4]

Magnesium chloride hexahydrate solution is prepared by dissolving 33 g of magnesium chloride hexahydrate in 1 litre of water. 70 mL of the solution, containing 300 mg of elemental magnesium can be taken everyday after breakfast. It is important to remember that although no side-effects have been noticed in all the cases reported so far, there can be gastrointestinal side effects such as nausea, diarrhea, vomiting and reduced appetite. Magnesium chloride has also been found to be effective in Darier's disease, atopic dermatitis, diaper dermatitis and eczematous dermatitis

To conclude, oral magnesium chloride solution offers a novel treatment for HHD. However, larger scale studies are needed to establish its efficacy, potency and safety in the treatment of dermatological diseases.

References

1. Borghi A, Rimessi A, Minghetti S, et al. Efficacy of magnesium chloride in the treatment of Hailey-Hailey disease: from serendipity to evidence of its effect on intracellular Ca^{2+} homeostasis. Int J Dermatol. 2015; 54: 543-8.
2. Barde NG, Mishra DB, Ingole SO. Oral magnesium chloride: A novel approach in the management of Hailey–Hailey disease. Indian J Dermatol Venereol Leprol. 2017; 83: 259-62.

3. Gu K, Silver S. A Case of Hailey-Hailey Disease Managed With Oral Magnesium Citrate and High-Dose Vitamin D_3. J Cutan Med Surg. 2018; 22: 362–364.
4. Sudbrak R, Brown J, Dobson-Stone C, et al. Hailey-Hailey disease is caused by mutations in ATP2C1 encoding a novel Ca^{2+} pump. Hum Mol Genet. 2000; 9: 1131-40.

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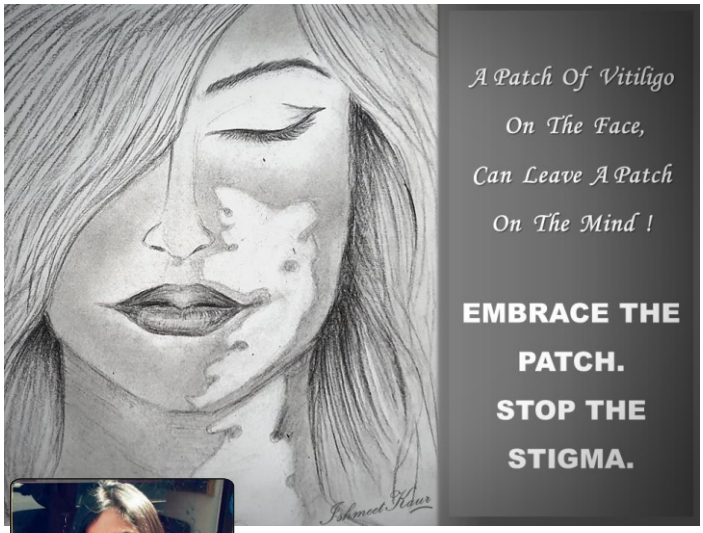

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Systemic lupus erythematosus (SLE) Classification Guidelines - A short review

Systemic lupus erythematosus (SLE), being a condition with complex pathogenesis and highly variable clinical manifestations, is a difficult disease to grasp and define. The danger of over-diagnosing or under-diagnosing by dermatologists and rheumatologists alike, is a potential pitfall due to errors in treatment, compounded by the development of adverse effects dealing with long term drug toxicities. The purpose of having classification criteria helps to maintain universal approach to stratifying a possible case of particular disease, in this case, the immunopathologically mediated condition SLE.

Previous Classification

Lupus classification, as given by the 1997 ACR criteria had a specificity of 93.4%, but a low sensitivity of 82.8%.[1]

The 2012 Systemic Lupus International Collaborating Clinics (SLICC) classification criteria improved upon the previous one, with the addition of mucocutaneous and neuropsychiatric features, as were hypocomplementemia and new antiphospholipid antibody tests; thereby refining the criteria. Thus, the SLICC criteria emphasized that SLE is primarily an autoantibody disease, and requiring at least one immunological criterion to be present. Furthermore, histology-proven lupus nephritis alone, was sufficient criteria for the diagnosis of SLE.[1] Although the 2012 SLICC criteria addressed some of the shortcomings of the ACR criteria, the specificity was only 83.7% and sensitivity, 96.7%.

The most recent 2019 EULAR/ACR classification for SLE has improved the sensitivity and specificity (96.1% and 93.4% respectively) which is significantly higher than SLICC criteria.[2]

Significant updates

In the 2019 EULAR/ ACR classification criteria, at least one positive ANA test is an obligatory criterion. If the patient tests ANA negative consistently, they cannot be classified as having SLE.

There are seven clinical domains and three immunological, each with a different score. Criteria do not have to occur simultaneously, and within each domain, only the criteria with the highest weight counts.

What the future classification holds

The role of biomarkers in SLE holds promise in the further classification of SLE. They include, but are not limited to, miRNA, B cell activating factor, CD44v3, CD44V6, complement C4d monocyte chemoattractant protein-1 (MCP 1).[3] This may help further stratify patients, detect early cases or atypical manifestations of the disease and predict response to therapy. The challenges will remain accessibility to testing, reproducibility at various centers, and ease or simplicity in formulating classification criteria with a high sensitivity and specificity. The times are exciting ahead with the advent of better therapeutic agents, targeted therapy and the responsibility of diagnosis of lupus, in the hands of appropriately trained dermatologists.

Entry criterion
Antinuclear antibodies (ANA) at a titer of ≥1:80 on HEp-2 cells or an equivalent positive test (ever)

↓

If absent, do not classify as SLE
If present, apply additive criteria

↓

Additive criteria
Do not count a criterion if there is a more likely explanation than SLE.
Occurrence of a criterion on at least one occasion is sufficient.
SLE classification requires at least one clinical criterion and ≥10 points.
Criteria need not occur simultaneously.
Within each domain, only the highest weighted criterion is counted toward the total score§.

Clinical domains and criteria	Weight	Immunology domains and criteria	Weight
Constitutional		***Antiphospholipid antibodies***	
Fever	2	Anti-cardiolipin antibodies OR	
Hematologic		Anti-β2GP1 antibodies OR	
Leukopenia	3	Lupus anticoagulant	2
Thrombocytopenia	4	***Complement proteins***	
Autoimmune hemolysis	4	Low C3 OR low C4	3
Neuropsychiatric		Low C3 AND low C4	4
Delirium	2	***SLE-specific antibodies***	
Psychosis	3	Anti-dsDNA antibody* OR	
Seizure	5	Anti-Smith antibody	6
Mucocutaneous			
Non-scarring alopecia	2		
Oral ulcers	2		
Subacute cutaneous OR discoid lupus	4		
Acute cutaneous lupus	6		
Serosal			
Pleural or pericardial effusion	5		
Acute pericarditis	6		
Musculoskeletal			
Joint involvement	6		
Renal			
Proteinuria >0.5g/24h	4		
Renal biopsy Class II or V lupus nephritis	8		
Renal biopsy Class III or IV lupus nephritis	10		

Total score:

↓

Classify as Systemic Lupus Erythematosus with a score of 10 or more if entry criterion fulfilled.

Current guidelines for SLE classification – 2019 EULAR/ ACR classification

References:

1. Petri M, Orbai AM, Alarcón GS, et al. Derivation and validation of the Systemic Lupus International Collaborating Clinics classification criteria for systemic lupus erythematosus. Arthritis Rheum. 2012; 64: 2677-86.
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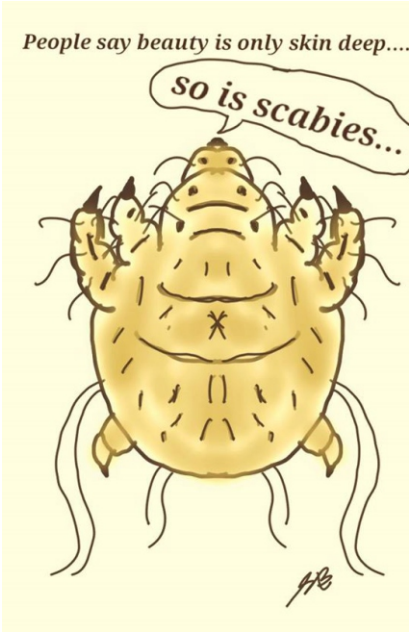

Rumination

What makes people get out bed?

What motivates people to work?

What makes success worth it?

Why do people constantly seek validation?

The more you think, the more clueless you'd feel. I've been thinking things over since adolescence. I hoped being an adult would finally give me an answer. It didn't, until I was exhausted and gave up on trying to make sense of events making apparent sense to other people. I realized that things don't have to have meaning to them. Following what your heart truly wants is all you need to look forward to. Not just a hope for a better tomorrow, but a belief that you'll make it better.

Birth and death are equally important- those are only 2 days in your life which don't have 24 hours. Yet one is a celebration of life, and the other a feared conclusion of life. One who doesn't fear death is truly fearless.

How much courage would it take to see an oncoming train, yet have the strength to not move from the track? Yet suicide is considered a cowardly act, and people who do think of it are stigmatized. We, as part of medical fraternity should rise above our social constructs and look at things with scientific temperament. We should aspire to make people around us happy, not just barely functional - being social, grooming yourself, going to work and contributing to society aren't necessarily markers for a good mental and physical health. Seriousness shouldn't be confused with sincerity, and an emphasis on a casual approach to work, and life is a must.

"Why revere life and delay something as inevitable as death?" I asked a monk in Mcleodganj. He smiled, asked me to close my eyes, and said, "Feel the wind. Why would you choose not to experience this? It's precious, what you have been given. Happiness is where you want it to be, seek it and you'll never find."

I spoke without a pause, offended at his suggestion, "Why should I let someone tell me that life is precious when I don't feel so? Is your judgement better than mine? I didn't ask to be born, but I can choose to leave. What gives anyone the right to deny me my free will? Is that not what we consider a human right? Freedom, as long as it doesn't infringe anyone's rights. I should be able to do with my body as I please. I can work hard and live a life like anyone else, I have till now, worked through ups and downs, and I can walk miles more, but there's nothing that awaits me at the end. Only death, and a false sense of contentment of having lived a fulfilled life, working day and nights to fulfill social expectations. What for, I ask? To not be labelled as insignificant?"

He smiled again. "So many questions, no answers in sight, no end to your plight. Taking your life is an end you cannot come back from. An act you cannot undo. A life you forfeit. Potential lost. The human mind changes every second, new thoughts come and go. If that's how you feel now, acknowledge it. Does that mean you are sure you would never feel another way? That you'd never find the purpose to your life? I'll not tell you what your family will feel, I'll not make you feel guilty for questioning existence. Sit, close your eyes, and find meaning. Find a why, you'll find a how."

Finding that 'why' is why some of us chose to be doctors. To heal a fellow human, whether in body or mind, is the greatest satisfaction of all, and having the ability to do that is reason enough to live.

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Reminiscence

The other day
I remembered
Crossed steps that
Tingled with fear
Heavy the weights
They had dragged
Willingly back to prayer
We wonder how we land into darkness
Careless words that mime
Dismember the bravest of worlds
Living an emotional time
Every cough a curse,
Smile suspect:
Your mind, your will,
A liability,
Yet somehow you accept.
Do you question?
Never,
Till the sun breaks through.
Do you then?
Never,
Till you're warmed true.
And now that the leaves
Glisten
With beauty not cold
Now that the grip
Is yore of old
Righteousness grips
Against silence
My fingers twitch
For your penance:
Me, I would have lived
Me, I have lived before
But I have shuddered knowing
The reality
Of how monsters grow.

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Skin and deep

Here they come, trying to protect the protector
A scope in the neck, fancy one in the hand
Long-standing diseases, wishing for a magic wand!

Life must be easy, nights would be breezy
Said the colleagues, this specialty isn't wheezy!
Its 2 am, slumber in my lash
“Hey derm, we got an acute rash!”

The dermis is exposed, losing water and salt
Necrolysis has set in, the bugs won't halt
Steroids? and antibiotics, think and act fast,
Catch the culprit or your patient won't last

Here, comes a DRESS, not one from the store
His skin is thick, his muscles are sore
Fever, hepatitis, eosinophils galore
One of these 20 drugs, oh! there are more!

“Can't sleep at night, my skin is shedding.
Sick of the itch, the scales on my bedding.
People's stares, hit me like glares”
“Let me hold your hand I will be there”

Not everything is contagious
The stigma is outrageous
Against the change in colour
Sometimes darker, sometimes paler.

Medicine or surgery, we have all the fun
What gets us worried are your days in the sun
That funky mole, hope isn't an aftermath
How can we forget, our dear dermopath!

A newborn child, his skin is peeling
Dystrophic or simplex, your mind is reeling
Paramount is the mother's feeling
Be compassionate in all your dealings

A pleasant adolescent, bullied at school
Belittling acne, is work of a fool
Let's treat the patient, not the disease
Build the confidence, the suffering should cease.

The botulinum toxin is our best friend,
Not only cosmetic, it is pleiotropic
From lines of fret to axillary sweat
It helps treat them all, I can bet!

The list is long, we 'face' a zillion issues
If I were to write a song, we will need some tissues
Let's end by saying, we are skin and deep
Beaming with pride for our dermatology peeps.

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Subhadarshani, S. (2020), Skin and deep.
Clin Exp Dermatol. doi:10.1111/ced.14109

Words create magic

Not everyday will be good
Dry tears sometimes
fill in my eyes
waiting for a reason to pour.
Everything becomes a blur.
But the thing that is good,
in these worst of times;
Is that this is when I write!
A flurry of thoughts cross my mind,
I itch to pick the paper,
And so I write.

A new day arrives;
So do I have any choice?
I resign in my mind, and go back to the grind.

A tid-bit of hope
An ounce of faith
A zest of energy
And a little confidence
Awaken the broken soul!
Life again goes on a roll
Waiting for adventures- new and untold
Looking for ways to unfold.

Alas again I hit a rough patch
There comes a slope; I pick my pen
for words are the voice of the soul.
Words; so deep and profound,
touch the paper
And magically cure my ailing heart.
The beautiful words sew round and round;
So powerful are words
That they bring me freedom
To soar so high; like a bird;
Far away from the groaning world!

My friend, my friend
You are a warrior
Your story is written in the sky
The universe has it there
Can a small thing like that make you weak!
And take you away from the things you seek?

The answers lie there;
but the vision is to be yours
The mind must not falter
and the heart must follow.
The journey may be long,
The journey may be dark
But the thrill of positivity
Hides all pain of negativity!

The beautiful words make everything better;
relaxed I feel, so much in control.
I love how words flow and sew
They heal the scars
And I grow roses inside
I hear the birds sing
The violins are playing
Can you hear the beat?
Come on life
Its time for the next feat!

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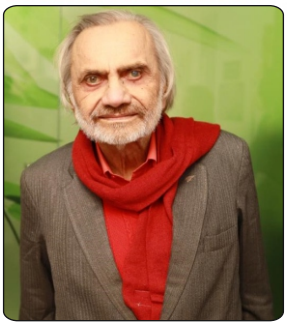
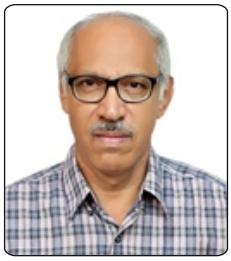
Professor Virender Nath Sehgal



Professor Virender Nath Sehgal came into the scene at a time when the subject of Dermato-Venereology had few takers and also needed a class of people who could elevate it. Prof. Sehgal was one among them. He completed his Masters degree from AIIMS, Delhi and quickly took up a teaching position in Aligarh Muslim University and later on entered the Central Health Service as the youngest Professor to serve in Goa Medical College. Here he had to develop the department from scratch: an endeavour into which he put his whole mind and heart. His main thrust to showcase the work in the college and to make it renowned was to publish research articles in specialty journals. This later on became his trademark to such an extent that there is not a single topic about which he has not in some way expressed his opinion!

When Goa had attained statehood, he was transferred to Delhi where he served in Safdarjung Hospital for a short while before shifting to Maulana Azad Medical College. He last served as the Principal of University College of Medical

Sciences, Shahdara. In all these institutions his voracious appetite for publishing remained and with whomsoever he worked, he would push them hard to do the same. His nature at times seemed overbearing, but beneath the tough exterior was a person who took great pride in the ones he tutored. I still remember that when exam-going postgraduates went to him for his good wishes, he would nonchalantly reply, "Remember, you all could also fail", but that was far from what he had in mind and stood his ground to see that his candidates fared well. As a person he was helpful wherever he could do something and willingly offered help even if any of his students had not asked for it. Even after retirement he kept a close contact with the people who had served under him and used to encourage them to publish more, a quality that he carried with him to the end; this was evidenced by his son-in-law Prof. Rajesh Malhotra who at the prayer meeting said that when Prof. Sehgal was in the Intensive Care Unit, his first words on attaining consciousness conveyed his desire to complete the chapter for a textbook he was authoring. He would in his free time discuss the nuances of cricket and politics, on which he had strong views. He is survived by his wife Dr. Naresh Sehgal and three daughters, all of whom are settled well. May his soul rest in peace.



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Dr. (Brig.) Pran Nath Arora

Remembrance

Dr (Brig.) Pran Nath Arora, an astute academician and a passionate professional was a graduate of the prestigious Government Medical College Amritsar and a postgraduate in Dermatology from the Armed Forces Medical College, Pune (1973). He served in the Indian Armed Forces as a dermatologist in a number of hospitals, including the Armed Forces Medical College, Pune and Army Base Hospital Delhi as the Professor and Head of the Department. He was one of the youngest postgraduate teachers in the early 70s and trained numerous postgraduates in his academic career, mentoring and guiding them. He was honoured with a fellowship in Dermatopathology at the prestigious National Skin Institute, Singapore in 1982. A prolific writer, with over 100 publications, his work in cutaneous cysticercosis and leishmaniasis was well recognized, in addition to his publications on sexually transmitted diseases. He was well-known to propound the theory of 'spectral diseases' where he described a number of conditions belonging to the same spectrum but presenting differently owing to the host immune response. He set up the first HIV centre of the Armed Forces and was instrumental in drafting of the first HIV policy and instituting antiretroviral therapy. His policies laid down the framework to be followed for management of pregnancies in sero-discordant couples.

He was awarded the lifetime achievement award of the IADVL Delhi State Branch. An upfront, disciplined officer and an impeccable administrator, he was commended by the General Officer Commanding-in-Chief for the work done by him.

Playing lawn tennis, gardening and photography were his passions other than Dermatology.

A devoted, supportive and proud husband and an indulgent father, he is survived by his wife Dr. (Lt. Gen.) Punita Arora, a gynaecologist and the first lady Lieutenant General of the Indian Armed Forces, dermatologists son and daughter-in-law, Group Captain (Dr.) Sandeep and Dr Gulhima Arora and daughter Dr Sabeena Arora, a cardiologist.

He is missed as a mentor and guide. May his soul rest in eternal peace.

Dr. Sandeep Arora, Dr. Gulhima Arora
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CRUCIVERBA.....

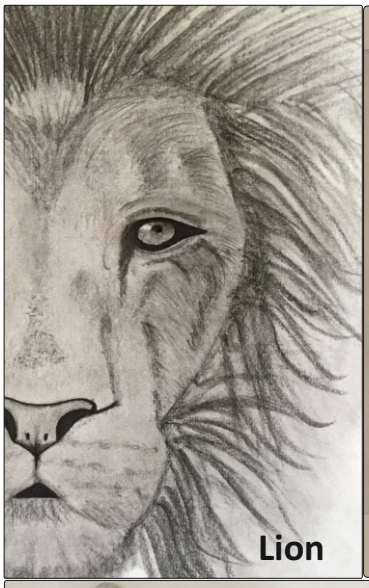
Answers :

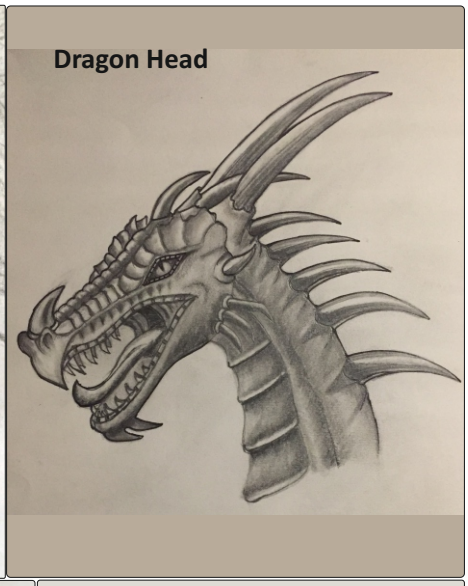
Across

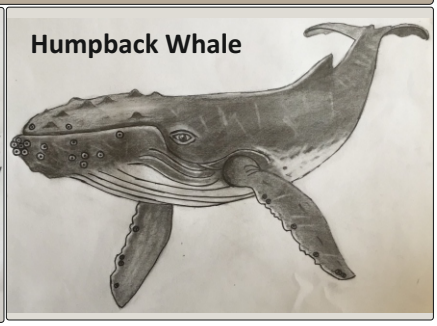
2. Malakoplakia
7. Glomus
8. Hobnail
9. Kassowitz
11. Crohn
12. Erlotinib
15. Tanino
17. Fischer
18. DISH
19. Marshall
22. Lofgren
24. Cockayne
25. Reed
26. Merkel

Down

1. Degos
3. Arunalokei
4. Kairo
5. Alizarin red
6. Touton
10. Pelvis
13. Netherton
14. LAMB
16. Fuchs
17. FISH
20. LEOPARD
21. Paget
23. NdYAG
24. CYLD







Dr. Rajat Kandhari
Consultant Dermatologist and Specialist in Aesthetic Procedures
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Group Captain (Dr.) Sandeep Arora
Senior Advisor, Professor & Head
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Friends,

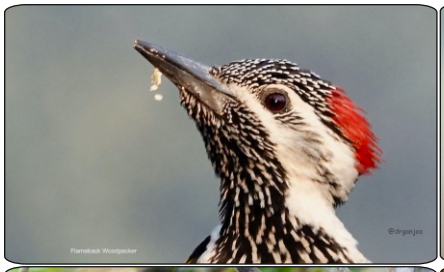
About 15 years ago, I would never have dreamt of getting into birding and photography. My brother in law, who has been an avid bird photographer for long inspired me with his wonderful skills at the art of bird photography. And, therefore, my journey as a bird photographer started in 2009, with my first trip to Keoladeo National Park, Bharatpur.

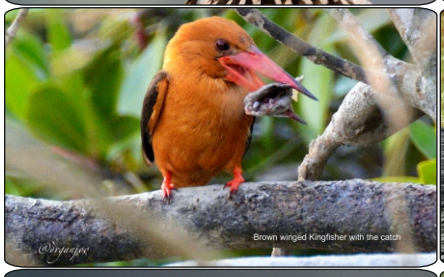
I was mesmerized at the bird life that I saw at this birders' paradise. And then there was no looking back. I graduated from point and shoot cameras to SLRs and then to high end tele lenses. As our profession takes us all over the globe, I have had the fortune of clicking at some of the most exotic locations in the world. But believe you me, India with its vast variety of fauna and flora is one of the best in the world for both bird and animal photography.

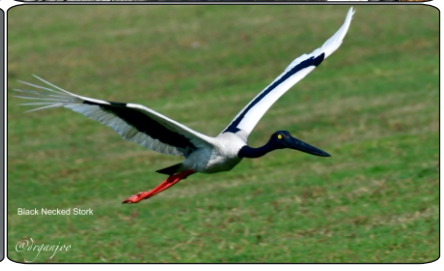
So, here's sharing a few of my bird clicks.

Hope you enjoy them.

Dr. Anil Ganjoo
Consultant Dermatologist
Skinnovation Clinics, Delhi







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