



neiadvl

NEWSLETTER

Official mouthpiece of N.E. States Branch of IADVL



Dr. Pranjal Jyoti Dutta

Respected and dear members,

Health is one of the major component of social development and also a basic human right. Health sector is vastly influenced by the socio-political establishment. Political scenario and stability impact very profoundly on the health system of that area. Policies and implementations are frequently disturbed by changing air of politics. We do witness disruption and shut down of health care system during the phase of not only election but also for a long period, prior and after election. Many good policies and schemes are withdrawn during transition of political power and leadership, only to meet narrow political ambition and agenda. The common people suffer a lot due to lack of proper health facilities, medication, man power, etc. Health care systems should be in continuous mode and progressive momentum uninfluenced by political conflicts of different persons and ideologies. So health sector deserve a long term and continued strategy to fulfill its primary goal, that is building up the basic health care needs of the common people. It should be made free from all political evils and pollution, though the government is the core of policy making and implementation. Besides health system must get its full priority in all frame, as it is the backbone of a country and its manpower. Fund allocation and release should be impartial and not provoked by political interest and inclination of a particular place and segment of people.

We do hope whichever the political group remain in power, they make a time bound, well monitored and progressive framework for health care system. To introduce newer and upcoming ideas and wisdom in health system, government should stress on bringing fresh and effective think tank from medical fraternity also, who are above narrowness of party politics and devoted too. Besides the torch bearers of medical fraternity should come forward to contribute their insights in policy making, beyond their role of only care provider. This bi-directional action will certainly take on our health system to a newer height.

At last, I do humbly welcome all delegates to this Mid-Cuticon at Barpeta and convey my all best wishes for your professional and personal life.

Long live NE-IADVL.

Pranjal Jyoti Dutta

Editor
NE-IADVL, Newsletter

MESSAGE FROM PRESIDENT, NORTH EAST STATES BRANCH, IADVL



Dear friends

It is a matter of immense pleasure to know the MID-CUTICON - NE 2016, being organized at Barpeta on 28th may, a truly magnificent location known for its history and culture.

I do hope, this time the occasion will be a very successful one for all the participating members of NE -IADVL. I hope the NEWSLETTER of this issue will also be a very good one as ever before. Long live NE -IADVL

S.K. Bhattacharya
DR.S.K.BHATTACHARYA

Secretarial Message, Mid-CUTICON 2016, North East States Branch IADVL



It is my pleasure to present before you yet another edition of the "NEIADVL Newsletter", the coveted mouthpiece of the North East States Branch of IADVL at the Mid-CUTICON 2016 to be held at Barpeta Road.

The newsletter has served as a medium for exchange of views & knowledge among the members and I am sure the Editor, Dr. Pranjal Jyoti Dutta, has left no stone unturned in making it a success.

I wish a grand success to the newsletter as well as the Mid-CUTICON 2016.

Warm Regards

Dr. Nasiur Rahman
Secretary, NEIADVL



Dear Colleagues,

On behalf of organising committee, it is my pleasure and privilege to invite you to Mid cuticon Northeast States 2016 at Barpeta road, Barpeta on 28th May 2016. It would be a great opportunity to meet and interact with your colleagues and friends. I sincerely hope that the conference will provide a wonderful forum to refresh and renew our knowledge and skills and explore the newer to newest innovation in the field of Dermatological science. We have invited eminent dermatologist from North East States for the Scientific session to speak and discuss on various important issues that we are facing in day to day practices specially in rural areas.

Barpeta is famously referred to as the 'Land of the Satras'. During the 16th century, Srimanta Sankardeva and his disciple Shri Madhabdeva launched a vigorous movement to promote Vaishnavite Art and Culture. Barpeta Satra, a renowned Vaishnavite temple was established in the year 1583 and in due course, many other Satras were built in the town. Hence, it acquired the names, 'Land of the Satras' and Satranagari. These Satras influenced the society in all forms by impacting the culture, lifestyle, politics and the economy. With the passage of time, the Satras developed further to become open universities dealing with various branches of education and arts, including music, dance, drama, sculpture, ivory work and many more.

We once again welcome you to Barpeta Road, Barpeta to attend Mid Cuticon Northeast States 2016 and make this event a great success.

Thanking you



Dr. Shafiul Islam

Organising Secretary

Mid Cuticon Northeast States 2016
Barpeta Road, Barpeta



Situated on the foothills of Himalayas, Manas National Park covers an area of 2837 sq. km. Declared a reserve forest in the year 1928, the park earned the status of UNESCO's World Heritage site in the year 1988. It earned the status of Biosphere Reserve in 1989. The park is an amazing combination of scenic landscapes and biodiversity. It is home to a wide range of wild animals including tiger, leopard, elephant, Assam roof turtle, Bengal florican, Himalayan black bear and golden langur. It is bird watchers' haven as there are more than 300 species of birds.



Barpeta Satra is one of the leading attractions in Barpeta. Ever since it was founded by Shri Madhabdeva over 500 years ago, the Satra remains the most influential identity of all Vaishnavite Satras in Assam. Kirtan Ghar, the prayer hall is the biggest of halls in Satras across Assam. Kirtan Ghar is a fine specimen of the architectural excellence in Assam during the Medieval period. Tourists from various parts of the world frequent Barpeta Satra.



Gorokhia Than is situated at Sorbhog, heart of Barnagar area. Koch King Naranarayan Established his temporary capital at Barnagar (1509). There is a legend that about 500 years ago the Than was founded by some cowherds (Gorokhia) where they found a wooden statue of lord Krishna (Balgopal). Later on the Than was shifted to a nearby place where it is presently situated. Sri Narayan Das Thakur Ata, a disciple of Srimanta Shankardev came to offer his devotion to the Than. Annually five festivals Bohag Bihu, Jogor Utsav, Janmas tomi, Magh Bihu and Deul Utsav are celebrated.



Pari Hareswar Devalaya is situated in Dubi. This ancient temple is dedicated to Lord Shiva. Shiva Singha, Ahom's king had made grants to the temple measuring 760 puras of land. It is believed that Queen Fuleswari was behind the introduction of Devadasis in temples. Devadasis, the temple dancers performed dances to amuse the deities in the temple. Devadasi-Nritya, a famous dance form, is considered to be originated here.

Activities of NEIADV (January – March 2016)

Compiled by **Dr. Anal Jyoti Bordoloi**

a) Chapter Activities :

Guwahati Chapter : The Guwahati City Chapter met twice since the last CUTICON 2015 at Agartala, Tripura.

11th December, 2015 : The programme consisted of 3 CMEs by 3 different speakers. The first CME was a case report on "Norwegian Scabies with an underlying Connective Tissue Disorder" presented by Dr. Ananya Kalita, PGT, GMCH. The 2nd CME was presented by Dr. Rajiv Kr. Gogoi on the molecule "Itolizumab". The 3rd CME was on the "Use of Cyclosporine in Dermatology" by Dr. Indrani Dey. The CMEs were followed by scientific discussions. The scientific programme was followed by a GBM to finalise the venues of Mid-CUTICON 2016 & CUTICON 2016. Barpeta Road was finalised for Mid-CUTICON & Guwahati for CUTICON. The issue of non-specialist doctors practising as consultant Dermatologists in different parts of Guwahati was also taken up & it was decided to write formally to the Assam Medical Council in order to look into the matter & take necessary steps.

12th of March 2016 : A CME on "Expanding Horizons of Fungal Infections" presented by Dr. Rashmi Agarwal, 2nd year PGT, GMCH and was followed by a scientific discussion on the rising concerns of resistant & recurrent tinea infections along with the latest management strategies to deal with them. This was followed by a GBM to discuss on the CUTICON NE States 2016. Guwahati was finalised as the venue although the dates were not finalised.

Dibrugarh Chapter : The Dibrugarh City Chapter was held on the 5th of March, 2016 at Hotel Royal Highness, Tinsukia. There were three scientific presentations which were –

- Lepromatous Leprosy – Case Reports by Dr. Moitryee Sengupta, PGT, AMCH
- Hair Disorders – focus on AGA & Telogen Effluvium by Dr. Ellis Khawbung, PGT, AMCH
- Topical Steroid Abuse – a Dermatologist's concern by Dr. Shyamanta Barua, Assistant Professor, AMCH

b) Observation of World Leprosy Day: The World Leprosy Day was observed in the various Medical Colleges of the region on the 31st of

January, 2016. Public awareness programmes like distribution of pamphlets, public lectures & shows on the electronic media were organised. Seminars & Symposiums were also organised not only among Dermatologists but also among doctors of other specialities & General practitioners to raise awareness on the early diagnosis & proper referral of the disease.

c) Awards: It was indeed a proud moment for NEIADV when Dr. K.K. Das, Former Prof. & HOD, Deptt. of Dermatology, GMCH was awarded the Guruvandana Award for Teacher per Excellence at the DERMACON 2016 at Coimbatore.



STUDY OF CLINICAL PROFILE OF PATIENTS WITH ATOPIC DERMATITIS

Author: Dr. Ashimav Deb Sharma
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INTRODUCTION

- ✓ (1) Atopic Dermatitis (AD) is a chronic condition of skin with a high prevalence rate (0.3-20.5% worldwide)¹.
- ✓ A rising trend in AD has been observed worldwide including in India in last few decades.

Possible explanations of the increase in the atopic allergy/dermatitis:-

- Increase awareness & improved diagnoses
- Increasing age of mothers
- Better parental education
- Smaller family size
- Increasing social motility
- Increase allergen exposure
- Decreased immune stimulation
- Improved hygiene
- Environmental pollution
- ✓ In an old study from Assam reported an incidence of 0.374% of the total number of Dermatology OPD attendees² in 2001. Similarly, a study from Bihar reported an incidence of 0.38%³.
- ✓ In this present study, different epidemiological factors and clinical manifestation of Atopic Dermatitis were analysed in 100 patients over a period of 2 years (appx).

METHOD

- ✓ A total of 100 cases of Atopic Dermatitis attending the DERMACARE CLINIC, BONGAIGAON (ASSAM), from March 2010 to April 2012 form the basis of present study.
- ✓ Diagnoses of AD cases were based on criteria proposed by Haniffin and Rajka (1980).
- ✓ All the patients were subjected to:
 - Detail history & clinical examination.
 - Swabs were taken from Skin lesions for culture and
 - Total Serum IgE level estimation

Criteria for Patient selection (Hannifin and Rajka, 1980)⁴:

Major Criteria: Must have 3 or more for diagnoses of AD.

1. Itching
2. Typical Morphology and distribution:
 - (a) Facial & extensor involvement in Infants and Children
 - (b) Flexural lichenification in adult
3. Chronic and Chronically relapsing dermatitis
4. Personal or family history of atopy, asthma, allergic rhinitis or atopic dermatitis.

Minor Criteria: Must have 3 or more minor criteria in addition to 3 or more major criteria for diagnoses of AD.

1. Cataract
2. Cheilitis
3. Conjunctivitis, recurrent
4. Eczema, Perifollicular eczema
5. Elevated level of Serum IgE
6. Facial pallor/erythema
7. Food intolerance
8. Hand eczema
9. Ichthyoses
10. Immediate (Type I) skin reactivity
11. Infection of skin
12. Itching when sweating
13. Keratoconus
14. Keratosis pilaris
15. Nipple eczema
16. Palmar hyperlinearity
17. Periorbital dermatitis
18. Pityriasis alba
19. White dermographism.
20. Xeroses.

RESULT AND DISCUSSION

Incidence:

- ✓ Out of 19,743 new cases attending the skin clinic for different skin problem during the study period, 100 cases were diagnosed as AD. The incidence of AD was 0.506%.
- ✓ A prior study from Assam reported an incidence of 0.374% of the total number of Dermatology OPD attendees² in 2001. A study from Bihar reported an incidence of 0.38% of the total number of outpatient attendees. Similarly, in two different studies, prevalence rate were noted to be 0.42% and 0.55%³.
- ✓ In the west, Habif et al⁵ noted an incidence of 7-24 per 1000 patients. The low incidence rate in the present study may be due to less number of cases in the series as well as apathy towards skin disease and personal hygiene in this part of the country.

Age and Sex distribution: In the present study of 100 cases,

- 60 patients were male and 40 patients were female.
- The youngest patient was 4 month old male infant and the oldest patient was 38 years old female.
- The male to female ratio were 3:2. Male preponderance was seen in all the age groups. The male to female ratio both in "Infantile AD" and the in "Childhood AD" group was 1.4:1.

Age Distribution	Male	Female	Total
00-02 years	16	14	30(30%)
02-12 years	32	22	54(54%)
12-20 years		20	02(2%)
20 years & above	10	4	14(14%)

Similar observation was also noted by Dhar S et al (1998)⁶. In a series of 672 children, they noted those males were affected more than female. The male to female ratio in "Infantile AD" group was 2.13:1 and in "Childhood AD" group was 1.09:1.

Occupation:

- ✓ preschool children (48 cases)
 - ✓ school going children (38 cases)
 - ✓ service holders (4 cases)
 - ✓ business group (4 cases)
 - ✓ housewife (4 cases).
- In this series, male children showed higher preponderance over female children.

Socio-economic status:

- ✓ The maximum number of cases (43% cases) belonged to higher Socio-economic status,
- ✓ 20% cases belonged to medium socio-economic status and
- ✓ 37% cases belonged to low socio-economic status.

Findings of the present study support the concept of "Hygiene hypotheses" which states that reduced early childhood infection because of improved living and hygiene standards can increase the risk of acquiring allergic diseases⁷. But important point is the gap between rich and poor is not so high.

Habitat:

- ✓ In this study, majority of cases (70% cases) belonged to urban population. Similar observation was also noted by William H et al (2008)⁸ in the west. Dhar S et al (1998)⁶ noted that higher incidence of AD in urban population in India.

The higher incidence of AD in urban population may be due to:

- Higher number of nuclear family in urban area.
- Better medical facilities in urban area.
- Higher level of environmental pollution in urban area.
- Stressful lifestyle in urban area.

Family pattern: In the present study,

- ✓ 54 cases belonged to nuclear family and
- ✓ 46 cases belonged to large family.
- ✓ Similar findings were noted by Vickers CFH (1980)⁹. In a series of 2000 cases, Vickers CFH et al noted a higher incidence of AD among those who belonged to nuclear family.

Age of Onset: In this study,

- ✓ 60 patients developed the disease within 6 months of age;
- ✓ 4 cases developed the disease in 6 months-1 year of age;
- ✓ another 20 cases developed the disease in 1-2 years of age and
- ✓ the remaining developed the disease after 2 years of age.

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✓ The findings in the present study are comparable with the findings of Dhar S et al (2002)¹⁰. In a series of 100 cases with AD, 25 patients developed the disease within 6 months of age; 6 patients developed the disease in 6 months- 1 year of age; 23 cases developed the disease in 1- 2 years of age and the remaining developed the disease after 2 years of age.

Seasonal variation: In the present study of 70 cases,

- ✓ 38 patients (54.28%) had a history of winter aggravation and
- ✓ 24 patients (34.28%) had a history of summer aggravation.
- ✓ Eight cases (11.42%) reported no seasonal changes.
- ✓ The patients belonging to 0-2 year age group was excluded to avoid responder's biasness.
- ✓ Similar findings were also noted by Rajka G (1961)¹¹ who noted that patients with AD experienced aggravation of their condition during winter; roughly one-third of the patients had aggravation of their skin condition during summer and in 10% cases there was no seasonal variation.

Birth Factor:

- ✓ In the present series, 30 patients were in the age group of 0-2 years. All the hospital papers related to the antenatal and post natal check up were examined thoroughly.
- ✓ It was noted that all the cases were born at term. 24 patients were born with normal birth weight and the remaining 6 patients were born with low birth weight.
- ✓ Out of the 30 patients, 18 patients were delivered by Caesarean Section.
- ✓ Olesan AB et al (1997)¹² studied children with AD and noted that children born after and with high birth weight were likely to develop AD in future life
- ✓ However, in the present study is not in support of the findings observed by Olesan AB et al. This may be also due to the less number of study cases in the present series.

Cradle Cap: In this series,

- ✓ 84 cases were in the age group of 0-12 years.
- ✓ out of 84 patients, 80 patients (95.23%) had cradle cap.
- ✓ Similar findings were noted by Dhar S et al (1998)⁶. They observed that 95.24% of patients with AD had either cradle cap or history of cradle cap in their infancy in a series of 672 children.

Xeroses:

- ✓ Out of 100 cases, xeroses were noted in all cases: winter aggravation was experienced by 96 cases while no seasonal variations were noted by the rest..



Cradle cap



Facial Eczema

Facial eczema: It was noted that

- all the 30 patients in 0-2 year's age group had facial eczema at the time of presentation.
- Six cases (11.11%) in the age group of 2-12 years had facial eczema of which 4 cases (14.2%) were from the age group of 6-12 years.
- The result of the present study is in support of findings noted by Sinha PK et al (1972)¹³, Queilli-Roussel et al (1985)¹⁴, Dhar S et al (1998)⁶ and Dotterud LK et al (1995)¹⁵. Sinha PK et al¹³ and Queilli-Roussel et al¹⁴ observed that involvement of face is very common in infantile AD. Dhar S et al and Dotterud LK et al¹⁵ noted that the involvement of face in infantile stage was very common and the incidence of facial eczema in AD in 6-12 year age group ranges from 10-12% in their series.

Facial Pallor: Out of 100 cases with AD

- 48 cases had Facial Pallor (Male: 28 and Female: 20). Majority of cases belonged to 2-12 year age group.

Morphology: In the present series,

- 96 patients had typical morphological pattern & distribution of their dermatitis.
- Result of the present study is similar with that observed by Rajka G et al (1980)⁴
- Four cases in the series had "reserve pattern" of morphology.
- Vickers CFH (1980)⁹ introduced the term "reserve pattern" to describe extensive lesions occurring both on the flexor and extensor aspects of limbs in some patients with AD in a series.
- In the present of study of 15 cases in 0-2 years age group, majority of the patients had extensor involvement of the elbow and knee in addition to the involvement of face, scalp and upper trunk.
- Sinha PK et al (1972)¹³ also noted predominant involvement of extensor surface in cases of "Infantile AD" in a series.



Flexural Eczema

Personal and Family history of Atopy: In the present study, it was noted that

- 20 patients had personal and
- 50 patients had family history of atopy respectively in the series.
- Roth et al (1964)¹⁶ observed family history of atopy in 62% of cases.
- Haniffin and Rajka (1980) reported family history of atopy in 70% of cases. Rystedt (1985)¹⁷ observed family history of atopy to be 51% and 43% in two different studies. Thus the present study is in conformity with the above studies.
- On the other hand, Kumar P et al (1998)¹⁸ had noted 56.25% and 63.75% cases had personal and family history of AD respectively in India.
- The wide variation in the personal and family history of atopy in different studies may be due to the variation in the expression in the atopic tendencies in the personal and family level.

Food allergy: In the present study,

- Food allergy was recorded in 9 cases in the age group of 2-12 years.
- The food items noted were cow's milk, Soybean, egg, prawn, Masoor dal and wheat. Food allergy was confirmed by oral challenge test.
- Out of 9 cases with food allergy, eight patients were born during the period of autumn to winter. These findings are in conformity with the popular belief that food allergy is more common in those atopic child who are born in autumn to winter season.
- In the west, Lever R (2001)¹⁹ observed 15-35% cases with AD had food allergy. The result of the present study is much less than Lever R; this is probably because of small number of patients in the study group.

Sweating: In the present study question relating to sweating were asked to the patients. Patients in the 0-2 year group were excluded.

- Out of 70 patients, 28 cases (40%) gave history of reduced sweating. This present finding support the observation made by Sulzberger MB (1947)²⁰ who noted that sweat retention may occur in AD cases due to poral occlusion of sweat gland duct resulting in reduced sweating.

Skin Infection: In this study all the patients were subjected to skin swab for culture of bacterial growth.

- 88 cases showed growth of bacteria from the swab taken from skin lesions.
- Out of the 64 cases who had exudative lesions, 62 cases (93.75%) showed growth of Staph. aureus (60 cases) and Pseudomonas (2 cases).
- Out of 36 cases who had dry lesions, 26 cases (72.22%) had showed the growth of Staph. aureus.
- Similar findings were noted by Leyden TJ (1974)²¹ and Gry W. Cole (1980)²². Leyden TJ et al noted that Staph. Aureus was present in 90% of cases with chronic plaque & 100% cases with exudative lesions.

Hyperlinear Palm:

- In this study, 34 patients presented with hyperlinear palm.

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- Uehara M et al (1981)²³ observed 28% of patients with AD had hyperlinear palm in a series of 178 patients.
- Fartasch M et al (1989)²⁴ noted 17 of patients with AD had hyperlinear palm in a series of 49 patients with AD.

Ichthyoses: In the present series,

- no ichthyoses was noted in the 0-2 year age group.
- Twenty cases had ichthyoses in the age group of 2-12 years; 2 patients had ichthyoses in the age group of 12-20 years.
- Twelve patients had ichthyoses in the adult age group.
- Ichthyoses is observed to be present in 30-40% patients with AD in different studies in the west^{23,24}.

Itching: In the present study, all the patients had itching of variable grade. Twenty eight patients had mild, 32 patients and 40 patients severe itching at the time of presentation.

Atopic Thigh:

- It was noted that 6 cases in the age group of 2-12 years had atopic thigh at the time of presentation. The age of the cases were in between 7-9 years. The percentage of AD cases with atopic thigh under 15 years of age came out to be 11.11%.
- The finding is similar to the observation made by Fredrickson G (1981)²⁵ who recorded 13% cases of AD had atopic thigh.

Pityriasis alba: Out of 100 cases with AD,

- 6 patients had P.alba in the age group of 0-2 years and
- 30 patients with P.alba in the age group of 2-12 years.
- It has been reported to occur in 20%–44% of atopic children, with or without other evidence of AD in the west. (Mevorah B et al, 1988)²⁶.

Juvenile Plantar Dermatoses: In the present study, 6 (11.22%) children (age group: 2-12 year) had JPD at the time of presentation. The present findings support the observation made by Verbov JL (1978)²⁷ who noted that 11.5% of children with AD had JPD in a series of 104 patients with AD.



Hyperlinear Palm



Juvenile Plantar Dermatitis

Nipple Eczema:

✓ Nipple dermatitis is noted in 12%–23% of patients with AD (Rudzki E et al, 1994)²⁸. It is most common in postpubertal girls. The very sensitive areolar skin koebnerizes with the slightest rubbing or friction of clothing. It is frequently symmetrical, scaly, oozing, and papulovesicular, and it may extend onto the adjacent breast skin.

✓ In the present series of 100 cases with AD, 2 adult female patients had nipple eczema. The result of the present study is much less than Rudzki E et al; this is probably because of small number of patients in the study group.

Dennie-Morgan Line:

✓ Dennie-Morgan lines²⁹ are symmetrical, prominent folds, extending from the medial aspect of the lower lid.

✓ It is seen in 60%–80% of atopic individuals. These folds are usually present at birth, or appear shortly thereafter, and persist for life.

✓ In the present study, it was noted that 70 cases had single fold Dennie-Morgan Line and 10 cases had double-fold Dennie-Morgan Line.



Dennie Morgan Fold

Anterior Neck Fold: Anterior neck folds are noted as prominent, horizontal folds running across the middle of the anterior neck of some atopic patients..

- Out of 100 cases, 35 patients with AD had ANF (Male:25 and Female: 10). Majority of cases belonged to the age group to 2-12 years.

Periorbital Dermatitis: Out of 100 cases,

- 24 patients with AD had Periorbital Dermatitis; of which,
- 14 patients belonged to 2-12 years age group,
- one patient in 12-20 year age group and
- remaining 9 cases belonged to adult age group.

Scaling from Scalp: In the present series, 16 patients had Scaling from Scalp at the time of presentation. Amongst them, 12 patients belonged to adult age, 2 patients in the 12-20 year age group and the remaining patients in the 2-12 year age group.



Scaling from Scalp

White Dermographism: In this present study,

- It has been noted that 80 cases had shown white dermographism. Majority of these cases belonged to the age group of 2-12 years.
- Mollar H (1972)³¹ had observed positive White Dermographism in all cases with AD in a series.
- Uehara M et al (1977)³² in a series, demonstrated White Dermographism in 60% of the patient with AD.
- In the present study, it was not possible to elicit white dermographism in very young patients therefore few percentages of cases might have been missed in the present series.

Cataract:

- In the present series of 8 patients who constituted the adolescent and adult age group, two had bilateral immature cataract which was confirmed by Ophthalmologist.
- This finding is similar to that noted by Hurlbut WB et al (1954) who noted the incidence of cataract amongst the atopic to be 3-10%³³.

Peri auricular Eczema: Out of 100 cases with AD,

- 28 patients had Infraauricular eczema and
- 20 patients had Post auricular eczema
- while 12 patients had eczema at the both sites at the time of presentation. Majority of the patients belonged to 2-12 year age group.

Hand Eczema: In the present series, 16 children were found to have hand eczema at the time of presentation. Dhar S et al (1998)⁶ observed the incidence of hand eczema due to AD to be 13.64% in a series of 672 cases. However a higher percentage was noted by Briet R et al (1972)³⁴. They noted 69% cases of AD with hand eczema in a series of 130 patients. This may be due to differences in various influencing factors like climate, personal hygiene, frequency of use of soap, availability of medical facility etc in the society where the study was conducted.

Wool Intolerance: All the patients in the age group of 2 years and above had history of wool intolerance. Patients in the age group of 0-2 years were not included to avoid repoder's biasness.

Serum IgE level:

- Serum IgE level was estimated in all 100 cases.
- Eighty eight cases had higher IgE level.
- Similar findings were noted by Juhlin L et al (1969)³⁵ who recorded a rise in serum IgE level in 80% cases with AD in a series.

Hertoghe's sign: This condition is characterized by the lack of outer third of eyebrows.

- In the present series, 2 adult patients had Hertoghe's sign.

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Hertoghi's sign



Pompholyx



Xeroses

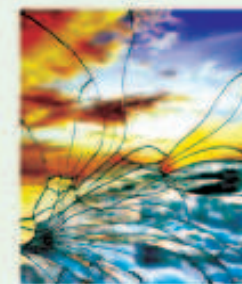
CONCLUSION

With few exceptions, the result and observation of the present study is similar with several other studies carried out by different authors in different part of the world. However the present study is a clinic based study and the study group was small. So, the result of this study should not be viewed as the representative of entire area. A further multicentric study comprising of large number of AD patients are required to achieve a more perfect result.

REFERENCES

1. Carroll CL, Balkrishnan R, Feldman SR, Fleischer AB Jr, Manual JC. The burden of atopic dermatitis: impact on the patient, family and society. *Pediatr Dermatol* 2005; 22:192-199.
2. Sharma AD. Allergic contact dermatitis in patients with atopic dermatitis: A clinical study. *Indian J Dermatol Venereol Leprol* 2005; 71:96-8.
3. Kanwar AJ, De D. Epidemiology and clinical features of atopic dermatitis in India. *Indian J Dermatol* 2011; 56:471-5.
4. Haniffin JM, Rajka G. Diagnostic feature of atopic dermatitis. *Acta Derm Venereol Suppl (Stockh)* 1980; 92: 44-7.
5. Habif TP. *Clinical Dermatology. A Colour Guide to Diagnoses and Therapy*. 2nd Edition. Philadelphia. CV Mosby, 1990:28-492.
6. Dhar S, Kanwar AJ. Epidemiology and clinical pattern of atopic dermatitis in North Indian pediatric population. *Pediatr Dermatol* 1998;15:347-51.
7. Herz U, Lacy P, Renz H, Erb K. The influence of infection on the development and severity of allergic disorders. *Curr Opin Immunol* 2000; 12:632-640.
8. Williams H, Stewart A, von Mutius E, Cookson W, Anderson HR: International Study of Asthma and Allergies in Childhood (ISAAC) Phase One and Three Study Groups, Is eczema really on the increase worldwide? *J Allergy Clin Immunol* 2008;121:947-54.
9. Vickers CFH. The natural history of atopic eczema. Presented at the International Symposium on Atopic Dermatitis 1979. *Arch Dermatol Venereol* 1980;suppl 92:113
10. Dhar S, Mandal B, Ghosh A. Epidemiology and clinical pattern of atopic dermatitis in 100 children seen in a city hospital. *Indian J Dermatol* 2002;47(4) :202-204.
11. Rajka G. Prurigo Besnier with special reference to the role of allergic factors. *Acta Derm Venereol (Stockh)* 1960;40:285-306 and 1961;41:1-39
12. Olesan AB, Ellinngsen AR, Olesan H et al. Atopic dermatitis and birth factors: historical follow up by record linkage. *BMJ* 1997;314:1003-8
13. Sinha PK. Clinical pattern of Infantile atopic eczema in Bihar. *Indian J Dermatol Venereol Leprol* 1972;38:179-84.
14. Queiie-Roussel C, Raunaud F, Saurat JH. A prospective computerized study of 500 cases of atopic eczema in childhood. Initial analyses of 250 parameters. *Acta Derm Venereol* 1985;114:87-92.
15. Dotterud LK, Kavemen B, Lund E et al. Prevalence and some clinical aspect of atopic dermatitis in the community of Sor Varanger. *Acta Derm Venereol* 1995;75: 50-54.
16. Roth HK, Kierland RR. The natural history of Atopic dermatitis. *Arch Dermatol* 1964;89:209-14.
17. Rystedt L. Prognostic factors in Atopic dermatitis. *Acta Derm Venereol* 1985;65:206-13
18. Kumar P, Pai OS. Atopic dermatitis: a clinical profile. *Indian J Dermatol* 1998;189:41-6.
19. Lever R. The role of food in atopic eczema. *J Am Acad Dermatol* 2001;45(Suppl 1) :557-60.
20. Sulzberger MB, Hill LW: Evolution of atopic dermatitis. *Arch Dermatol* 1947;32:451.
21. LEYDEN JJ, MARPLES RR, KLIGMAN AM. Staphylococcus aureus in the lesions of atopic dermatitis. *British Journal of Dermatology* 1974;Vol 90;issue 5;pg 525.
22. Cole GW, Silverberg NI. The adherence of Staph. aureus to human corneocytes. *Arch Dermatol* 1986;122:166.
23. Uehara M, Hayashi S. Hyperlinear palms: association with ichthyosis and atopic dermatitis. *Arch Dermatol*. 1981 Aug; 117(8):490-1.
24. Fartasch M, Diepgen TL, Hornstein OP. Are hyperlinear palms and dry skin signs of a concomitant autosomal ichthyosis vulgaris in atopic dermatitis? *Acta Derm Venereol Suppl (Stockh)*. 1989; 144:143-5.
25. Fredrickson G. The atopic thigh: a starting school syndrome? *Acta Derm Venereol* 1981;61:452-453.
26. Mevorah B, Frank E, Wietlisbach V, et al. Minor clinical features of atopic dermatitis. *Dermatologica* 1988;177:360-4.
27. Vervov JL. Atopic eczema localized to the forefoot. An unrecognized entity. *The Practitioner* 1978;220:465-466.
28. Rudzki E, Samochocki Z, Rebandel P, et al. Frequency and significance of the major and minor features of Hanifin and Rajka among patients with atopic dermatitis. *Dermatology* 1994; 189:41-6.
29. Morgan DB. A suggestive sign of allergy *Arch Dermatol Syphol* 1948;57:1050-3.
30. Meenam F. The significance of Morgan's fold in children with atopic dermatitis. *Arch Derm Venereol* 1980; suppl:12:42-43.
31. Moller H. Atopic winter feet in children. *Acta Derm Venereol (Stockh)* 1972;52:402
32. Uehara M, Ofuji S. Abnormal vascular reactions in atopic dermatitis. *Arch Dermatol*. 1977;113:627-9.
33. Hurlbut WB, Domonkos AN. Cataract and retinal detachment associated with AD. *Arch Ophthalmol* 1954;52:853-7.
34. Briet R. Zum Neurodermatischen Handekzen. *Arch Dermatol Forsch* 1972;244:353.
35. Juhlin L. IgE in dermatoses: Levels in atopic dermatitis and urticaria. *Arch Dermatol* 1969;100:12.

Poem

Behind a broken mirror

where the blue waves merge into the red jungle,
 where the silence so deep and timid, i stood alone
 you still in lovely tune, fall like a rain
 I dare to touch the forbidden sky,
 a sky never was mine, never was mine.
 where the sunset sets a fire, in the mighty horizon
 where the cry swept in thunder storm, I stood alone
 you still with that pearly dimple, twinkle in the dream
 and I dare to be a shadow of yours, in vain..
 where you were, i am there still, like a fallen leaf
 searching roots and trees, i am still there,
 behind a broken mirror, never to be seen....

Dr. Pranjal Jyoti Dutta

neadvl NEWSLETTER

THE TERROR OF INJECTION

DR. KRISHA RANI BORDOLOI
Junior resident , Deptt. Of Dermatology.
Jorhat Medical College

Getting an injection or a shot is an inevitable part of a healthy life style. everyone in this world have experienced this "painful" event once in their life-time in the form of vaccines or for therapeutic purpose. But the fear of needles and the pain they cause is a cause of anxiety for many. In fact this fear of being pricked reigns in everyone's heart, be a child or an elderly. I would like to cite an instance at this point- a real life incident of mine that still amuses me. I was just 10 years old, studying in class 4. Starting up for school early morning at that time seemed it so boring and punishing specially when the cosy bed at home reconns you to a world full of comfort and relaxation. One day I was so overburdened with my homework and unable to finish it on time decided to miss school by any

means. The thought of it incited in my tiny little brain dozens of crooked ideas that could rescue me from attending school. As per my master plan I acted a bit sick with a gloomy and "about to cry" type of face and started complaining of severe headache-with my head clasped in the palms of both hands and buried in my knees sat at one corner of the kitchen showing little interest to my favourite breakfast lying on the table in front of me! Worried at my pathetic state my mom enquired about the problem and decided to take me to a doctor. Showed sick on out-side but my heart was throbbing in happiness as I escaped what I hated the most- going to school without finishing home-work. As I was sitting in the waiting room at the doctor's chamber, I over heard the conversation of the other patients and their attendants sitting there. Suddenly the whole joy and the state of relief faded away as soon as I anticipated the fear of getting a shot. The person at the entrance shouted no.11 and I felt my throat getting dry and a lump sticking to it which I couldn't gulp. With a terror stricken face I followed my mom into the chamber where the doctor greeted us with a smile. I scanned the whole room for a person ready with a syringe to grab me and inject that painful thing. Mean-while my mother talked to the doctor and

after some clinical examination he started to write the prescription. But my heart pounded in fear as I anticipated the final verdict- injection or no injection? A gush of hot blood rushed into my head and I was bathed in sweat in that adrenalin rush(fright). However I was safe from getting pricked that time as the doctor advised to take rest and explained my parents that it was nothing serious. Oh! what a relief.....

And now as a doctor I can feel and sense the fear of injection that prevails in the hearts of patients of all ages. Some patients even directs doctors not to give injection and manage their illness only with oral medications. It feels funny and at times annoying too. We doctors know what to do -and when to put patients on injectables. Injections are not given to terrorise a patient, moreover how much does an injection pains?? Just the feel of sting of a mosquito in certain cases. But the fear that has found its place in the tender heart of the people during their childhood remains forever. During my student life in the hospital wards I have witnessed different reactions of different patients getting a shot. Some of them faint at the look of the small 5ml syringe on the sister's hand whereas others give such an expression they are going to get operated on without anaesthesia !! I could see the terror created by one of the most effective method of administering medicine. quite a number of people hide their actual health status and site various reasons to avoid seeing a doctor for their illness. it sometimes amuses me how a skin deep pain can terrorise people so much that they prefer to retain a discomfort, a disease for such a long period until it becomes really necessary for them to consult a doctor. No matter what and how a doctor treats, the terror of injection still prevails!!!

Treasurer's Report N. E. states branch, IADVL (from Nov 2015 to May 2016)

INCOME AND EXPENDITURE ACCOUNT FROM NOVEMBER 2015 TO MAY 2016

TOTAL COLLECTION	AMOUNTS	TOTAL EXPENDITURE	AMOUNTS
Collected money (provisional life membership fees 7000×3)	21,000/-	Money sent to Central Committee as provisional life membership fees	5550/-
Surplus money from MID CUTICON 2015, Nagaon	5000/-	To Dr.Prasanna Saikia for MID CUTICON 2015, Nagaon expenditure	81,590/-
Added collection from MID CUTICON 2015, Nagaon	91,460/-	Web.com Pvt.Ltd.	4293/-
Amount received from Gloderma for MID CUTICON 2016, Barpeta	1,51,900/-	To Avishek Media (for newsletter printing)	28,000/-
Interest credit	18,845/-	To Dr.Anita Baruah for CUTICON 2016	1,00,000/-
		To Dr.Sofiul Islam for MID CUTICON 2016, Barpeta	1,51,900/-
		To resource person ,Dr.Nitin Jain for Dermatosurgery workshop, May 2015, Guwahati	28,452/-
TOTAL INCOME	2,88,205/-	Total expenditure	3,99,785/-

Deficit amount = Rs.3,99,785- Rs.2,88,205=Rs.1,11,580/-

In our General Savings A/ C till November 2015 there was Rs.9,66,881/-

Now the amount in the same A/C is Rs.9,66,881- Rs.1,11,580=Rs.8,55,301 /-

Fixed deposits

1. Rs. 15,500/- (Matured on July 2014)
2. Rs.1,30,000/- (Matured on Sept. 2014)
3. Rs.1,08,605/- (Matured on July 2014)
4. Rs. 45,158 /- (Matured in August 2015)

Total Rs.2,99,263/-

Amount of money in the name of association Rs.2,99,263/- + Rs. 8,55,301/- =Rs.11,54,564/-

Dr. Chayanika Kalita
Treasurer,
N.E.States Branch, IADVL



Stress and Acne

Dr. Bornali Dutta (Ray Baruah)

Acne vulgaris, more commonly known simply as acne, is a milestone which one never misses in their journey to adulthood. It is an integral part of puberty and 80–95% of adolescents aged 12–24 suffer from acne. Fortunately for many, the prevalence declines dramatically after the age of 25. But it is sometimes seen to persist or emerge in later life too and 25% of all adult men and 50% of adult women at some time in their adult lives are seen to suffer from acne. Though it appears to be “a superficial nuisance” only and physically scarring acne accounts for less than 20%, yet, the burden of this condition on adolescent’s life and mental status can be considerable; it can not only cause a dent in their present but can also dim the prospects of a bright future.

Adolescence is a complex life-cycle stage characterized by many striking biological, physical, psychologic, and interpersonal changes. This era is usually conceptualized as consisting of 3 phases.

(1) Early adolescence, from age 10 to 13 years, coincides with the onset of puberty and many changes in school life. However, during these years the family is still a key context for the changing young boy and girl.

(2) In middle adolescence, from age 14 to 16 years, there may be increased evidence of changes in parent adolescent relationships and often increased conflicts in these family relationships, together with the adolescent’s growing attention to his or her emerging individual autonomy. It is also in mid adolescence that peer and romantic relationships become more salient. An attractive physical appearance contributes in a big way in building bridges in relationships and earning approval from their peers.

(3) In late adolescence, from age 17 to 21 years, adolescents often make important life decisions about life directions—committed enduring relationships, career/work, and further schooling. During this final phase, integration of self-images and overall identity formation are dominant themes as the adolescents move toward young adult years and roles. (1,2)

Stress is a constant in our lives, but for the acne sufferer it can be especially troubling. There seems to be a two-way street with acne and stress; acne can cause stress and negative emotions, and stress and negatives can cause and worsen acne. There is a vicious cycle between stress and acne that keeps the condition flaring up again and again even if one takes good care of their skin. The reasons linking stress and acne are multifactorial. Arck et al.(3) have reviewed the recent research offering solid evidence for a local neuroendocrine skin axis that operates as an important “brain-skin” connection. The skin and its appendages are capable of generating the same mediators that are used during systemic stress responses, and they have established a fully functional peripheral equivalent of the systemic, stress-activated hypothalamic-pituitary-adrenal axis.(4,5). The classical neuroendocrine pathway for response to systemic stress is by hypothalamic release of corticotropin releasing hormone (CRH), subsequent activation of pituitary CRH receptors (CRH-R), and production and release of proopiomelanocortin (POMC) derived peptides. Proopiomelanocortin (POMC) is a precursor polypeptide with 241 amino acid which is cleaved to give rise to multiple peptide hormones namely; α MSH, ACTH, β Endorphin and Metenkephelins. When the brain senses stress, the hypothalamus releases corticotropin releasing hormone. This hormone travels through the bloodstream to the adrenal glands, where it triggers the release of the stress hormone cortisol.

Skin cells produce both CRH and express functional CRH-R1, thereby supporting the existence of a local CRH/CRH-R neuroendocrine pathway that may be activated within the context of a skin stress response system. Thus, when the skin senses stress, it doesn’t have to wait on the brain to send a signal to the adrenal glands to release stress hormones. It makes its own CRH to respond to its own stresses which also instructs mast cells in the skin to release inflammatory chemicals like histamine. The skin becomes redder and itchier and swells, all because of heightened sensitivity in its nervous system.

CRH stimulates the sebaceous glands to produce more sebum. The added skin oil makes the skin more flexible—or wrinkled, depending on how long stimulation goes on. CRH also activates immune and inflammatory pathways responsible for stress induced acne. Keratinocytes are stimulated to release inflammatory chemicals like leukotriene to attack infectious microorganisms. In doing so, they can also attack healthy skin cells. The process of ductal hyperkeratosis is also stimulated which lead to entrapment of both sebum and bacteria within the follicles. The sebum that is trapped in the

pore is food for acne bacteria, which multiply rapidly. Acne bacteria do not usually irritate the skin. In fact, one of the byproducts of their digestion of excess sebum in pores is essential fatty acids that reduce inflammation in the skin. Resident bacterial flora in sebaceous follicles like *Propionibacterium acnes*, *Propionibacterium granulosum*, *Pityrosporum ovale* and *Staphylococcus epidermidis* play an important role in the production of acne. To protect themselves from the immune system, however, acne bacteria secrete chemicals that make surrounding skin cells more sensitive to inflammation. That way, when the skin makes stress chemicals, it is the skin itself that gets bombarded with inflammation, not bacteria. As a lesion eventually opens up, a few acne bacteria escape to go to live in a different pore.

Another part of the answer seems to be that stress interferes with the thyroid’s response to thyroid stimulating hormone, and low levels of thyroid hormone leave the skin more vulnerable to inflammation. Vitamin A and its topical derivatives are believed to help raise thyroid hormone levels when they heal the skin. And yet another explanation seems to be that stress increases production of not just testosterone but also two other sex-related hormones, luteinizing hormone and prolactin. Testosterone can increase sebum production leading to blockage of pores. At the same time, the skin is releasing inflammatory factors, adding to the pathogenesis. Good sleep is believed to increase the amount of melatonin in the brain which leads to less production of corticotrophin stimulating hormone thereby preventing the pathogenesis of acne.

One of the newest topics in acne research is the relationship between a psychiatric condition known as alexithymia and acne. Alexithymia which literally means “without words for emotions.” is a personality trait that causes difficulty in expressing, understanding, or describing emotions. Researchers have recognized for nearly 40 years that the inability to express or understand emotions makes all kinds of illnesses more likely and all kinds of treatments less effective. People who have alexithymia tend to get lower back pain, fibromyalgia, irritable bowel syndrome, allergies, asthma, nausea, and, scientists have recently discovered, acne. Having acne does not mean that one has alexithymia. However, having alexithymia increases the chances of having acne. The relationship between the inability to express emotions and the appearance of acne is explained in terms of the brain-skin connection. However, in a study by Sunay et al, results did not demonstrate a link between the two conditions. But the study was limited by its small sample size, age limitation and conducting at one center. Further multicenter studies with larger study groups and different age ranges may provide definite results. In a later study by Ozuguz et al on evaluation of alexithymia in patients admitted to a dermatology clinic,

scores of 50, 61, were obtained which though similar to the previous study were statistically significantly higher compared with our control group.(6,7) Although research works on alexithymia in dermatology are still scarce and reveal conflicting results, preliminary data show that alexithymia seems to be associated with some skin diseases

Acne is the most common problem that presents to dermatologists. It commonly affects young people at a time when they are undergoing maximum psychological, social and physical changes. Smithard et al. studied 317 students between 14-16 years of age and found that those with acne were more likely to score in the abnormal/borderline range for emotional or behavioral symptoms. Do et al. reported in their study that adolescents with definite acne had significantly high-score self-perceived severity, stress, and disturbances in interpersonal relationships and daily life. Kubota et al. found that students with acne were significantly more depressed than those without acne. In a cross-sectional study by Magin et al. it was found that ‘non-psychiatric diagnosis’ psychological morbidity-embarrassment, shame, self-consciousness, impairments of self-image, self-confidence and self-esteem, anger, and stigmatization-were more prominent than symptoms of anxiety and depression in patients with acne, psoriasis and atopic dermatitis.(8-11)

The relationship between the severity of acne and emotional distress is poorly understood. A study of university students showed that patients with acne experienced a worsening of their disease during examinations. Increased acne severity was significantly associated with increased stress levels. There is generally considered to be a linear relationship between the clinical severity of acne and impairment of quality of life (QoL). However, impairment is also dependent upon a person’s coping ability and some individuals with little objective evidence of acne may endure severe subjective impairment, greatly affecting their QoL. So acne can have a great impact on patient’s lives, often independent of severity.12-14

Continued from Page - 8

Severe acne is associated with increased depression, anxiety, poor self-image and poor self-esteem. Psychiatric symptoms are more common in more severe acne and in the later stages of puberty. Adolescent girls may be more vulnerable than boys to the negative psychological effects of acne.(15-17) Acne is associated with increased risk of depression, anxiety and suicidal tendencies and there are some important gender differences. In a regression model for body mass index and depressive symptoms, boys suffered from significantly lower self-attitude and girls from poor self-worth.(18)

Acne is one of the commonest conditions encountered in most dermatological out patient departments ,after infections and infestations. In the private set up also, dermatologists very frequently come across distressed patients and even more harassed parents. The new generation teenager seems much more affected by their physical appearance and its psychosocial impact than their predecessors. The large armamentarium of topical and systemic therapies available fail to bring a smile to expectant patients .It is only few cases of acne excoricee that receive the privilege of a psychiatrist or counselors evaluation and have the benefit of a dual consultation. Researchers have made it quite clear that acne is not only an expected physiological change influenced by pubertal changes centering around androgens , sebaceous glands and propionobacterium acnes. It goes much beyond to include the stress-activated hypothalamic-pituitary-adrenal axis at both central and peripheral level with profound mental and psychological consequences. This apparently innocuous cosmetic problem in reality runs very deep. Even if acne is not associated with severe morbidity, mortality or physical disability, it can nevertheless have considerable psychological and social consequences .The social, psychological and emotional impairment that can result from acne, especially in its more severe clinical forms has been reported to be similar to that associated with epilepsy, asthma, diabetes, back pain or arthritis. Patients could be more prone to immediate problems like depression, anxiety, social withdrawal and anger, not to mention the more persistent problems like scarring that can lead to lifelong problems with self-esteem.

Acne vulgaris is a common skin disease with potential complications that are more than skin deep. The treatment of acne should involve much more than addressing skin problems. Any treatment plan should include both physical and psychological care. The severe burden of acne is strong justification for effective acne treatment and psychiatric screening for patients with the condition. Most important, improvements in acne after appropriate treatment have been shown to result in enhanced self-esteem, body image and social functioning. A good amount of time needs to be invested not only in the quantitative assessment of the skin condition but also on the qualitative evaluation of its impact on the individual. A comprehensive approach where the clinical acumen of a dermatologist and the perceptive skills of a psychiatrist come together will unravel the ongoing burden of the condition on the individual. . This will help us envisage a suitable management approach which will be patient specific , curtailing not only time and financial loss and but also ensuring the exclusion of distracting factors, which hamper the progress of potentially equipped individuals. Adolescents and young adults will be at peace with their physical state and they will be able to focus on their goals in life . They will be armored by the time tested tools of success; self esteem and self confidence. Experiencing high self-esteem fosters a sense of confidence and positivity and serves as a protective factor in coping with new life changes. Effect of acne on an adolescent's wellbeing is often underappreciated. Increased understanding of the psychiatric comorbidities associated with acne and identifying the high-risk patients with early intervention will ultimately improve the patient's life.

References

1. Adams R, Berzousky M. Blackwell handbook of adolescence. Malden, MA: Blackwell Publishing; 2006.
2. Christie D, Viner R. Adolescent development. BMJ 2005; 330: 301-4.
3. Arek PC, Slominski A, Theoharides TC, Peters EM, Paus R. Neuroimmunology of stress: skin takes center stage. J Invest Dermatol. 2006;126:1697-1704.
4. Ito N, Ito T, Kromminga A, Bettermann A, Takigawa M, Kees F, et al. Human hair follicles display a functional equivalent of the hypothalamic-pituitary-adrenal axis and synthesize cortisol. FASEB J. 2005;19:1332-1334.
5. Slominski A, Wortsman J. Neuroendocrinology of the skin. Endocr Rev. 2000;21:457-487.
6. Sunay D, Baykir M, Gülfem Ateş G, Meral Ekşioğlu M. Alexithymia and Acne Vulgaris: A Case Control Study. Psychiatry Investig. 2011 Dec; 8(4): 327-333.
7. Ozuguz P1, Seval Dogruk Kacar S D1, Ahmet Hamdi Alpaslan A M, Celep B Uzel H. Evaluation of Alexithymia in Patients Admitted to the Dermatology Clinic. International Neuropsychiatric Disease Journal 2016 5(3): 1-8Ref
8. Smithard A, Glazebrook C, Williams HC. Acne prevalence, knowledge about acne and psychological morbidity in mid adolescence: a community-based study. Br J Dermatol. 2001; 145:274-279.
9. Do JE, Cho SM, In SI, Lim KY, Lee S, Lee ES. Psychosocial aspects of acne vulgaris: a community-based study with Korean adolescents. Ann Dermatol. 2009; 21:125-129.
10. Kubota Y, Shirahige Y, Nakai K, Katsuura J, Moriue T, Yoneda K. Community-based epidemiological study of psychosocial effects of acne in Japanese adolescents. J Dermatol. 2010;37:617-622.
11. Magin PJ, Pond CD, Smith WT, Watson AB, Goode SM. A cross-sectional study of psychological morbidity in patients with acne, psoriasis and atopic dermatitis in specialist dermatology and general practices. J Eur Acad Dermatol Venerol 2008;22:1435-1444.

12. Chiu A, Chon SY, Kimball AB. The response of skin disease to stress: changes in the severity of acne vulgaris as affected by examination stress. Arch Dermatol. 2003;139(7):897-900.
13. Walker N, Lewis-Jones MS. Quality of life and acne in Scottish adolescent schoolchildren: use of the Children's Dermatology Life Quality Index (CDLQI) and the Cardiff Acne Disability Index (CAD). J Eur Acad Dermatol Venerol. 2006;20(1):45-50.
14. Niemeier V, Kupfer J, Demmelbauer-Ebner M, Stangler U, Effendy L, Gieler U. Coping with acne vulgaris. Evaluation of the chronic skin disorder questionnaire in patients with acne. Dermatology. 1998;196(1):108-115.
15. Arnold L. Dermatology. In: Levenson JL, ed. American Psychiatric Publishing Textbook of Psychosomatic Medicine. Arlington, VA: American Psychiatric Publishing Inc; 2005:629-646.
16. Arnold L. Dermatology. In: Levenson JL, ed. Essentials of Psychosomatic Medicine. Arlington, VA: American Psychiatric Publishing Inc; 2007:629-646.
17. Kilkeny M, Stathakis V, Hibbert ME, Patton G, Caust J, Bowes G. Acne in Victorian adolescents: associations with age, gender, puberty and psychiatric symptoms. J Paediatr Child Health. 1997; 33(5):430-433.
18. Dalgard F, Gieler U, Holm J, Bjertness E, Hauser S. Self-esteem and body satisfaction among late adolescents with acne: results from a population survey. J Am Acad Dermatol. 2008;59(5):746-751.

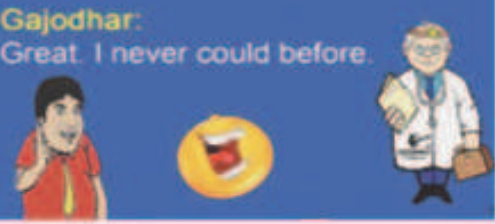
Jobs Of The Day

Old man has 8 hair on his head.
He went to Barber shop
Barber in anger asked:
shall i cut or count ?
Old man smiled and said
"Colour it!"
LIFE is to enjoy with whatever
you have with you,
keep smiling 😊😊😊


Gajodhar:
Doctor, will I be able to play the piano after the operation.

Doctor:
Yes, of course.

Gajodhar:
Great. I never could before.




Life is like a flute.
It may have many holes and
emptiness but if you work on it
carefully,
it can play magical melodies.



“If I could be any part
of you, I'd be your tears.
To be conceived in your
heart, born in your eyes,
live on your cheeks, and
die on your lips.” - Unknown

When I stand before God at
the end of my life, I would
hope that I would not have a
single bit of talent left,
and could say, 'I used
everything you
gave me'.

- Erma Bombeck




Life is an opportunity, benefit from it.
Life is beauty, admire it.
Life is a dream, realize it.
Life is a challenge, meet it.
Life is a duty, complete it.
Life is a game, play it.
Life is a promise, fulfill it.
Life is sorrow, overcome it.
Life is a song, sing it.
Life is a struggle, accept it.
Life is a tragedy, confront it.
Life is an adventure, dare it.
Life is luck, make it.
Life is too precious, do not destroy it.
Life is life, fight for it.

— Mother Teresa

i am grateful

At the end of our lives,
we will not be judged by
how many diplomas we
have received, how
much money we have
made or how many
great things we have
done. We will be judged
by how many souls
would bear witness for
us and say "I was
hungry and you gave
me something to eat. I
was naked and you
clothed me. I was
homeless and you gave
me shelter."

- Mother Teresa



neadvi NEWSLETTER

Glimpses of CUTICON, Agartala, 2015

