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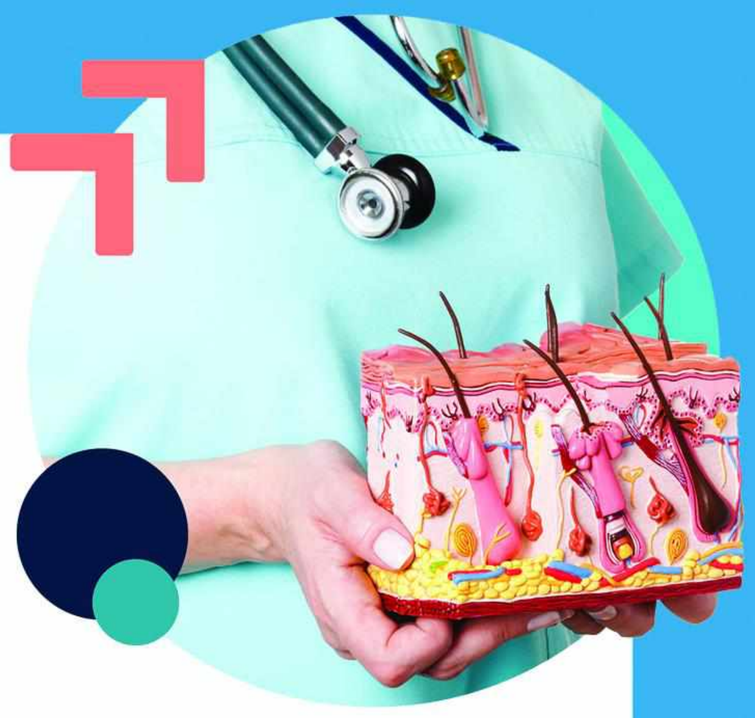
YUVADERMA - NORTH EAST STATES
Volume I, December, 2019

*"The good physician treats the disease;
the great physician treats the patient who has the disease."*

-William Osler



INTRODUCTION

YUVADERMA - an initiative undertaken by IADVL, was started as a pilot project by the state wing of Resident Connect Committee in Karnataka back in 2016. The idea was to create a common platform for the residents in Dermatology to not only communicate their experiences and knowledge, but also to feature and encourage their hidden talents. This novel effort was met with an overwhelming response from the residents in different regions of the state. Taking into account the success of the project, this year National Resident Connect Committee, IADVL has decided to extend YUVADERMA to all the other states.

Following this foot-steps, YUVADERMA- NORTH EAST was formed this very year and is headed by Chairperson, Dr Indrani Dey. This is an attempt to share the diverse ideas as well as experiences, and showcase the creative skills of the residents. Various articles ranging from some uncommon cases to fun facts in Dermatology, from lesser known topics to funny memes and crosswords are included. To encourage and nurture young residents, we also chose to feature an interactive session with the renowned Professor of Dermatology, Dr Pankaj Adhicari. Also we have tried to highlight the artistic and imaginative talents in sections such as "The Pixel Diary" and "The Artist Gallery".

Presenting you the concerted efforts of the residents from our zone, in the form of the first edition of YUVADERMA - NORTH EAST bulletin. We hope our readers enjoy the bulletin as much as we had savoured the moments in its making.

FROM THE EDITOR'S DESK

The team of NE- YUVADERMA, the state wing of RESIDREAM is very happy to announce the release of its 1st edition. This bulletin is in its true sense for the residents and by the residents. I am very much grateful to my mentors for having faith in me and my abilities to fulfill the role as the Editor-in-Chief for the 1st edition of YUVADERMA North-East. It was a big task for me as I have never been a part of such activity. Being the inaugural issue added to my mixed emotions of happiness and nervousness. But the help and support of the team and other residents was immense, without which it would never have been possible for me.

I am thankful to Dr Indrani Dey ma'am for guiding me through every stage of the preparation process. Her constant encouragement was really inspiring. I am honoured to take the responsibility at zonal level, taking cue from the prominent Editor-in-Chief of RESIDREAM, Dr Preethi Nayak. I am grateful to my enthusiastic and talented team of Dr Lily Singha, Dr Ziaul Haque Ahmed, Dr Hitesh Khatri, Dr. Bhawna Lochav, and Dr. Linda Kongbam for being very supportive and for coordinating the whole matter among various colleges of the North-East. It is true that the energy of the youth is unmatched and has the potential to bring about change. Dr Saloni Katoch, the founding editor of Yuvaderma was always there for any help. "YUVADERMA NE STATES" owes its genesis to all the post graduates, who have painstakingly worked through various topics and skillfully composed the articles that will appear in this edition. Yet amongst all, I take this small opportunity to acknowledge and thank the contribution of Dr Lily, who has persevered immensely and put a lot of effort in shaping YUVADERMA bulletin. A bulletin needs a lot of compilation, editing and designing, but Dr Lily was utterly devoted to its making in the most brilliant way. We from the YUVADERMA team are most grateful to you.

This issue starts with an interactive interview with Professor and Head of the Department of Dermatology, GMCH, Dr Pankaj Adhicari - an eminent dermatologist, academician and the constant source of knowledge and encouragement for the young residents. The other highlights of the issue are words of advice from Dr Saloni Katoch in the form of a piece "Crossroads", the lesser discussed but important and upcoming topic, Psychodermatology aptly written by Dr Priyanka Nawani and the myth and misconceptions about our branch written by our enthusiastic resident, Dr Ziaul. Sections like The Pixel Diary and The Artists Gallery are collections of photographs, sketches and paintings contributed by the residents, including a few last minute sketches by Dr Yusufa Ahmed. It is aptly said that laughter is the best therapy and not only the body, but our brain needs constant exercise too - so we have added some funny memes prepared by Dr Amlan Jyoti Sarma and a crossword beautifully created by Dr Lily. Being the maiden issue, we have tried our best to minimize the errors but we do anticipate few shortcomings. Our readers are welcomed to bring to our notice any shortcomings or errors along with new ideas and suggestions for the future issues. Happy readings!

Dipak

Dr. Dipak Kr Agarwalla

Editor in Chief, Yuvaderma

MESSAGES

I am really very happy to pen a few lines for the very first edition of the Yuvaderma NE bulletin. It is heartening to know that NE States is among the first few branches to start Yuvaderma, the first was started in 2016 by the Karnataka branch.

Residream, the national wing of the residents has won accolades from all. We have our very own Dr Saloni, who has contributed largely to this success.

Our dear residents, I request you to come forward and reach out and do connect with each other so that you can showcase your talents and stand tall. I am fully assured that Dr Dipak will be the right person to strengthen Yuvaderma in the NE STATES and bring it to the top slot one day.

With best wishes for the maiden venture

Dr. Basubi Barua
President, NEIADVL

YUVA SHAKTI ZINDABAAD!!!

So goes the age old saying and I often think how true it is. They are full of energy and bright ideas.

The yuva or youth are the frontrunners of a better and brighter tomorrow. As the field of Dermatology is seeing its greatest boom in recent years, I wish that this platform of youthful interaction serves as an important step towards working individually and jointly in carrying Dermatology to even greater heights of recognition in the Medical arena.

Be forever inquisitive and also, continue to write and share whatever new you encounter because you never know how your small discovery might change the face of tomorrow.

Last but not the least, I thank and congratulate each one of Dr Lily, Dr Hitesh, Dr Bhawna, Dr Ziaul and Dr Linda for whom NE YUVADERMA is seeing the light. Special thanks goes to Dr. Dipak Kr Agarwalla who coordinated the whole process of evolving NE YUVADERMA and worked tirelessly with the whole of team NE YUVADERMA to bring this issue out.

Dr. Indrani Dey
Secretary, NEIADVL

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MESSAGES

Dear Residents,
Warm Greetings!
First and foremost, it gives me immense pleasure to know that IADVL - North East branch has come up with YUVADERMA this year. I would like to congratulate the whole team: Dr Linda, Dr Hitesh, Dr Lily, Dr Bhawna and Dr Ziaul for their hard work and dedication. The dawn of this edition reflects the efforts of zealous IADVL – North East Yuvaderma, Editor-in-Chief: Dr Dipak Agarwalla. Yuvaderma North East would not have been possible without respected Dr Indrani Dey, Chairperson, Yuvaderma – NE, who has left no stone unturned in introducing this platform and releasing the 1st ever Yuvaderma NE newsletter for the benefit of residents.

Yuvaderma was first started by IADVL, as a pilot project in Karnataka back in 2016. Now, it is spreading its branches throughout India, in unison with the National Resident Connect Committee, IADVL and growing into a strong and deep rooted tree of knowledge - with full of fruits, in the form of success which it has been experiencing up till today. It is a platform which has consumed time, patience, hard-work and toil of a lot of residents and respected IADVL EC committee members. But at the end of it when I look at the way it is shaping up, it not only fascinates me but makes me happy to be a part of it.

Yuvaderma is for young budding dermatologists to showcase and nurture their talents. Dermatology being on top today, its residents are among the brainy, skillful and competent minds. Given a right platform at the beginning of their career, they can showcase and accomplish in plenty. Yuvaderma is one such platform, where the residents can express themselves without any restrictions and to the best of their ability.
Yuvaderma has been reaching greater heights due to collective efforts, hence I request all the residents to actively participate in various activities conducted by National Resident Connect Committee, IADVL and Yuvaderma – North east.

The 1st issue of the newsletter is here now; I am sure it will be a masterpiece and one of its kind.
Hope you have a good read!

Dr. Preethi B Nayak
Convenor,
National Resident Connect Committee
IADVL (2019-20)

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DR PANKAJ ADHICARI

Candidly Unplugged

Professor Dr Pankaj Adhicari is a well known academician and an eminent physician. A beacon of knowledge and values, Sir has been a role model to many young budding residents. He is presently the Head of the Department of Dermatology, Venereology and Leprology in Gauhati Medical College and Hospital. In this interview, he talks about how to navigate our professional life and has shared his journey, ideologies and experiences. Edited excerpts:

Lily: Good Morning Sir. First of all, we would like to thank you for taking out time from your busy schedule for this interview.

Sir: Good morning. Take a seat. I would love to interact more with my students. I will gladly answer all the questions you have for me.

Lily: Without further ado, Sir, we would love to have a little peek into moments and experiences that has led you to this successful point in life. How would you describe your journey from the day you chose Dermatology as your subject of specialty?

Sir: My journey in this field started the day my cloud of confusion disappeared - between General Medicine and Dermatology. I had initially developed an interest and liking towards Dermatology during my internship posting in 1992. During my house job tenure in General Medicine, my mentor, Professor of Medicine, Dr S. Umar sir encouraged me to pursue Dermatology as he saw this subject as one which had great scope in future. In addition to it, I observed that in the health camps which we visited those days, more than one-third of the patients were suffering from skin ailments and there were just a handful of Dermatologists in Assam at that point of time. Among them were my teachers - Dr K. N. Baruah sir, Dr Jogesh Das sir, Dr Jyoti Nath ma'am. The dearth of doctors in this field also inspired me to choose this specialty. I finally joined as a junior resident in Dermatology in the year 1993 and completed my post-graduation in 1996. After my selection in APSC examination, I joined Gauhati Medical College as Registrar. Subsequently, I got promoted to Assistant Professor in 2002. I was transferred to Assam Medical College in the year 2012 and was promoted next year to Associate Professor. After 3 years in Dibrugarh, I was transferred back to Guwahati and in the year 2017, I was promoted to Professor of Dermatology and was given the responsibility as the Head of the Department, a position I am holding till date.

Bhaskar: What are the aspects of Dermatology which has made it your favourite subject? What makes it different from other specialties?

Sir: As I mentioned earlier, my love for Dermatology started since my internship days. When we compare with other specialties the physical pain which our patients encounter is lesser than the mental agony they suffer. This again leads to psychological illness. The constant questions and prejudice from the society, which a person with a visible skin condition face in their day-to-day life, has a great impact on their mind. Patients with Hansen's disease and STI are often judged and neglected by their relatives and society. When we help these patients with proper treatment and improve their condition, it brings great satisfaction and peace, not only to the patient but to our mind. With the increasing awareness among the general population these days, greater sections of our society needs our service and dedication.

Lily: What are the changes you have noticed in the scope of Dermatology as a subject in present times as compared to the time you started out as a junior resident?

Sir: There are vast changes in this specialty that we have witnessed since my days as junior resident. During those days, very few medicines were available. For eg -in cases of fungal infections, only Griseofulvin was available as systemic therapy. These days there are multiple treatment options available - for vitiligo, we can go for PUVA therapy, NBUVB therapy, vitiligo surgery, etc. Preparations of sunscreen and emollients were scarce. Now-a-days, huge number of preparations are available for a particular drug and the treatment options are still growing with each day. Dermatosurgery, Dermatopathology, Cosmetology and Aesthetics are all upcoming and very popular sub-specialties in our field.

Bhaskar: How do you manage to maintain a balance - being a consultant, an academician and an administrator at the same time?

Sir: It all depends on how well one manages his time. That is the most important thing and is the key to balance every aspect of one's life. I use my free time to keep myself updated - for both my students and my patients. I go through the books, journals, and recent advancements in management of different diseases. I try to limit my consultancy time and not go overboard. I try to fulfil the role of a teacher and responsibilities as the Head of the Department with the best efforts I can make and the patience that I have.

Lily: What are the challenges you are facing these days as a dermatologist?

Sir: As I have given you a picture of how the management of patients in Dermatology has changed since our time as residents, I would say it has been easier than those days. The challenge that I am facing these recent times are in cases of Pigmentary disorders - both hypopigmented and hyperpigmented lesions. In patients with vitiligo, there are cases with relapse after treatment with NBUVB, excimer laser, vitiligo surgery; and not all institutes have these facilities. Apart from this, I am facing problem in management of fungal infections.

Bhaskar: Sir, would you kindly guide us through the clinical approach regarding case studies? Any tips regarding the study methods?

Sir: Yes, definitely. The 3 year post-graduation course is enough if one utilizes his/her time properly. Every student should inculcate the habit of reading, right from the 1st year itself and dedicate at least 2 hours a day. Every PGT should attend the clinics for a minimum of 2-3 hours and examine at least 20 cases a day. Discussing different cases, especially the unusual ones with seniors and teachers will help in developing and refining one's clinical approach to such cases. This habit would help to narrow down the list of differential diagnosis while dealing with unusual cases. Timely review and follow up of patients is equally important to assess the response of the treatment. Simultaneously, one should try to remain updated regarding the recent advances in Dermatology. This would definitely help in becoming a successful dermatologist.

Lily: What kind of skills should we as Dermatology PGTs acquire and sharpen in these 3 years with regard to different procedures we perform in the minor OT?

Sir: During my post graduate days, there was a paucity of different facilities and equipments such as EC, RFA, lasers etc. All we had was just a scalpel and TCA. Over the years, we gradually added the facilities that our patients could avail today. In addition to sharpening the clinical acumen during these 3 years of post-graduation, one must try to develop a firm grasp over these dermatosurgical and cosmetological procedures starting from the basics.

Bhaskar: What are the thumb rules that you would like to share with us?

Sir: There are many miniscule things which hold a great deal in our day to day life. While interacting with the patients, a polite attitude is of prime importance. Proper treatment protocol should always be accompanied by counseling. At the same time, unrealistic assurances should be avoided. The next thumb rule I would like to share is that the treatment we chose for the patients shouldn't be a financial burden to them. Lastly, one's punctuality and up-to-date knowledge of the diseases will also aid further in this scenario.

Lily: Sir, what is your opinion regarding the importance of counseling in management of the patients in Dermatology?

Sir: Counseling is very essential in Dermatology, as majority of the diseases are chronic in nature. It is mandatory to always keep patients well informed about the disease process, its course and prognosis, treatment options available and the stages of improvement. Explaining the importance of adherence to treatment and timely follow-up is very important. At the same time, we aren't supposed to overburden and frighten the patient with information that aren't relevant. During the PG curriculum, students should be sensitized about the importance of proper counseling and should be guided well while developing these skills.

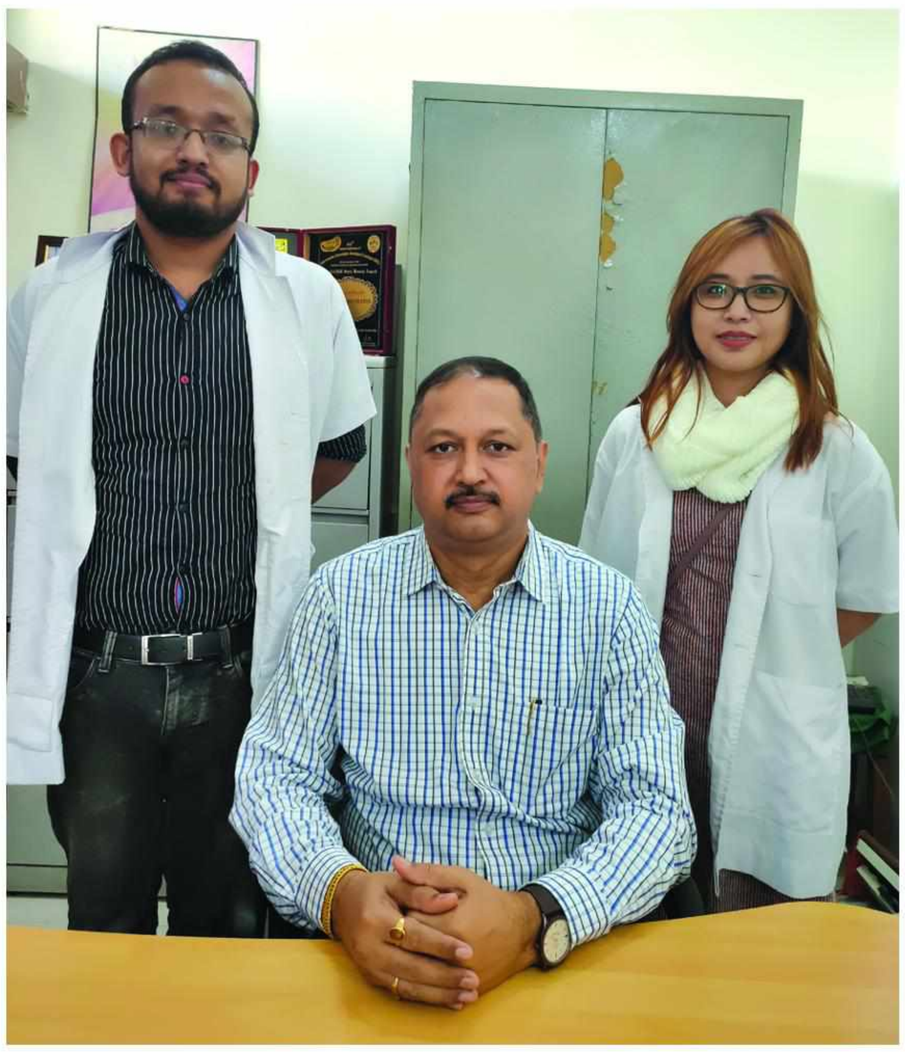
Lily: Sir, there's a recent surge in the medico-legal cases & harassment of medical practitioners - both physical & mental. What's your take on this issue – who's to be blamed? The new generation practitioners or the public or the press/media? Any advice for safe practice for new generation dermatologists?

Sir: I am deeply aghast at witnessing such scenario in the society these days. It's a difficult task to single out one definite cause for such happenings. One should be cautious while counseling the patient by not giving unrealistic expectations. On the other hand, there are some patients who are very difficult to please. So, our approach towards each patient should be individualized. Proper documentation, written informed consent and photographs for comparison (carried out before and after the procedure) should be meticulously maintained to avoid the conflict with patients.

RAPID FIRE QUESTIONS

1. Tea OR Coffee: Tea.
2. Sunrise OR Sunset: Sunrise.
3. Traditional food OR Continental food: Traditional.
4. Mountains OR Beaches: Mountains.
5. Guwahati OR Chayygaon: Chayygaon.
6. Favourite movie: None in particular. Any light-hearted Hindi movie does the job.
7. Favourite song: Songs of Bhupen Hazarika and Lata Mangeshkar.
8. Favourite travel destination: Goa.
9. Any nicknames: 'Junti' in my hometown, 'Basu' during hostel days.
10. If not a dermatologist, alternate career you would have chosen: IPS officer (Indian Police Service).

By- ***Dr Lily Singha***
&
Dr Bhaskar Jyoti Kalita
2nd year PGTs
Gauhati Medical College and Hospital



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Psychodermatology
- *where the mind and skin interact*

Dr Priyanka Nawani
1st Year PGT
Assam Medical College and Hospital, Dibrugarh

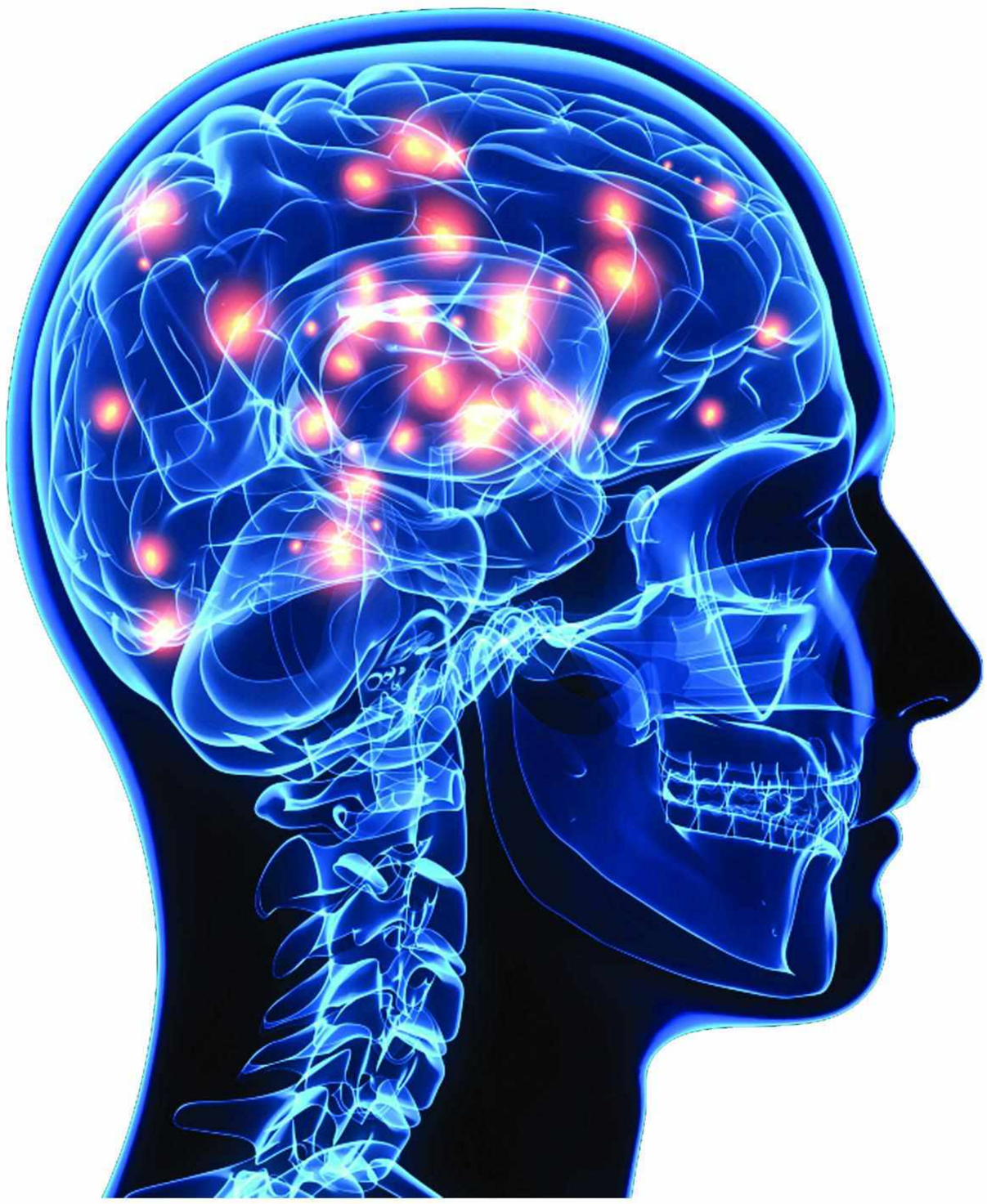
Have you ever wondered?

Why we blush when we are embarrassed or suddenly develop goosebumps when we are scared or frightened or in fact why does an acneform eruption appears a day before our BIG DAY?

Is there any connection between the brain and the skin - the largest organ in our body, to respond in a certain way? Or is it trying to communicate if something is alright or amiss through the skin?

If that is the case, i.e, if the brain is actually controlling the skin to respond in a certain way, then can we train our minds to deal with certain skin conditions or at least reduce its severity or recurrence?

This where the branch of Psychodermatology, a subspeciality between psyche and dermatology comes into play. It is a branch that combines principles of dermatology, psychiatry and psychology to provide a holistic approach to manage the patients with skin diseases as it acknowledges the effect of skin on psyche and vice versa.



The brain and skin both develop from the same surface ectoderm. As a result, both have a strong connection. The brain can influence the skin immune cells through receptors and chemical messengers, which in turn, upregulates the stress hormones that increase the cortisol, substance p and CGRP levels causing mast cell activation. This finally leads to immune dysregulation culminating into the DISEASE.
For eg: in a study on psoriasis 37 - 78% individuals believed that stress aggravated their condition and recurrent flares were attributed in 80%of psoriasis patients.

They say, love the skin you are in!! But how can you do so when you are constantly judged, questioned or even isolated just because you have a visible skin condition like psoriasis or vitiligo. People with diabetes and hypertension live freely in the society without being judged but people with skin conditions are constantly repelled. All of this constant cycle of rejection and feeling of unworthiness creates anxiety, psychological stress and depression in these patients which makes their skin conditions recur or even worsen in some cases by initiating the stress cycle .

Our aim is to break that cycle and prevent the occurrence of the diseases.

This includes a multidisciplinary approach, where patients are administered with medications to treat the dermatological conditions along with various psychological therapies like cognitive behaviour therapy - that deals with the dysfunctional thought pattern or actions causing damage to the skin and also facilitate aversion therapy and produce desensitization.

The second important thing is biofeedback exercises which produce progressive muscle relaxation and imagery techniques that shifts the focus from sympathetic system to the parasympathetic system, thereby, reducing the stress levels.

In general, the connection between skin disease and psyche has, unfortunately, been underestimated. More than just a cosmetic disfigurement, dermatologic disorders are associated with a variety of psychopathologic problems that can affect the patient, his/her family, and society altogether. Therefore, increased understanding of these issues, biopsychosocial approaches, and liaison among primary care physicians, psychiatrists, and dermatologists could be very useful and highly beneficial. Creation of separate psychodermatology units and multicenter research about the relationship between skin and psyche in the form of prospective case-controlled studies and multi-site therapeutic trials can provide more insight into this interesting and exciting field of medicine. ■

ACCIDENTAL DISCOVERIES IN DERMATOLOGY

Compiled by- ***Dr Hitesh Khatri***
3rd year PGT
Gauhati Medical College and Hospital

On the quest to find a sailing route to the Far East, Columbus landed in the New World which we now know as the Americas. The discovery of Uranus by the famous astronomer William Herschel while making observations in the constellation of Gemini strikes a similar chord. Likewise in the field of medicine too, a lot of discoveries can be attributed to serendipity and if not for the razor sharp observant skills of some scientists, we would still be lagging on many fronts.

Here are some of the accidental discoveries in the field of dermatology.

1. ***CYCLOSPORIN A (CSA):*** A drug with immunosuppressive properties was initially isolated from the fungus Tolypocladium inflatum (Beauverianivea), obtained from a soil sample in 1969 from Hardangervidda, Norway by Dr. Hans Peter Frey, a Saandoz scientist. Its immunosuppressive effects were discovered in 1972. Later, in a pilot study on effects of CsA in rheumatoid arthritis, four of the patients who also had psoriatic arthritis had almost total clearance of their psoriasis within a week of intake of CsA orally. Finally, cyclosporine was FDA approved for psoriasis in 1997.

2. ***MINOXIDIL:*** It was originally used as an oral therapy for hypertension. It lowers blood pressure by acting as a nitric oxide agonist and potassium channel opener. In 1977, hypertrichosis was noted as a severe cosmetic problem in 5 female patients using this drug as an antihypertensive. Subsequently, reversal of alopecia was noted in patients with minoxidil. In 1981, the drug was found to be of use in both alopecia areata and androgenetic alopecia. Few years on, minoxidil became the first drug approved by US FDA for the treatment of alopecia and it has progressed to become one of the most widely used medications for hair restoration, especially in androgenetic alopecia.

3. ***BIMATOPROST:*** Prostaglandin analogs are used in glaucoma to reduce intraocular pressure. Latanoprost, travoprost and bimatoprost have been widely used as eye drops. Incidentally these medications, when used for glaucoma, were found to stimulate eyelash growth and pigmentation. There appears to be an increase in anagen follicles, resulting in thicker, darker, and longer eyelashes. Since 2008, bimatoprost has received US FDA approval for use in cosmetic enhancement of eyelashes.

4. ***BOTOX:*** The use of botox in cosmetic and aesthetic dermatology has been a boon for patients. In 1987, a patient suffering from blepharospasm was being treated with Botox by Dr. Jean Carruthers, a Canadian ophtha-mologist. The patient was being administered small amounts to reduce the spasm, when she noted that with every injection of Botox, the wrinkles on the forehead between her eyebrows seemed to be disappearing, which made her look younger. Coincidentally Dr Carruther's husband, Dr. Alistair Carruther was a dermatologist. The wife narrated the fascinating story of her patient's wrinkles to her husband over dinner. To further convince her husband she injected Botox into the skin of their receptionist, Cathy Bickerton. The resultant disappearance of wrinkles convinced Alistair to investigate further.

5. ***THALIDOMIDE:*** It was first used as a drug to cure anxiety and tension in Germany in 1957. It was also found to reduce the symptoms of morning sickness and was therefore prescribed to pregnant women. Shortly thereafter, it was noted that a large number of children born to pregnant mothers taking Thalidomide developed a limb deformity known as Phaecomalia. Subsequently, the drug was withdrawn from the market. In 1964, an Israeli dermatologist - Sheskin, while treating a critically ill patient with Erythema nodosum leprosum administered the patient with few Thalidomide tablets in his possession to cope with the insomnia due to acute pain. The patient not only slept well but his lesions also improved considerably after taking Thalidomide. Since then Thalidomide, a banned drug due to its teratogenicity, has found a significant place in the treatment of leprosy.

6. ***TRANEXAMIC ACID:*** It is not a new molecule and has been extensively used in the treatment of menorrhagia since the 70s as well as for the prophylaxis of hereditary angioedema. This drug, a plasmin inhibitor, was used by Nijo Sadako in 1979 to treat a patient with chronic urticaria who also had melasma. A few weeks into the treatment, there was significant reduction of hyperpigmentation - an accidental result - eventually paving the way for its use as an oral drug for melasma.

7. ***FINASTERIDE:*** It is a 5-α-reductase type 2 isoenzyme inhibitor. The drug (5 mg per day) had FDA approval for treating benign hypertrophy of prostate since 1992. It was accidentally discovered to grow hair on the bald scalp of men who were taking this drug. The drug was shown to reduce scalp dihydrotestosterone levels by about 69%. Finasteride in the dosage of 1 mg per day was subsequently approved by US FDA for males with androgenetic alopecia in 1997. ■

the LOL zone

Post graduate trainees after THESIS submission

Memes by:

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1st Year PGT, GMCH

&

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MYTHS AND MISCONCEPTION ABOUT DERMATOLOGY

Dermatology is hands down the most misunderstood and underrated specialty. This is true not only amongst the medical fraternity but also outside it. I can tell you from experience because my own parents were against me opting for Dermatology and I had a really hard time convincing them. But once I did, they came to see my reasons for choosing the subject and they were happier than me with the choice. That's the beauty of our specialty. No one thinks too much about it. But when they look long and hard enough, they realise that Dermatology is more than just skin deep.

But what fuels this stereotyping, you ask? Well, we need look no further than our own brethren from other specialties. Young doctors going through medical school are conditioned into thinking that Dermatology is a non-essential subject - neither from an academic point of view, nor as a viable career option. I was greeted with quite a few disapproving looks from my peers and seniors when they came to know I opted for Dermatology. Everyone thinks Dermatology is easy and that anyone with some basic medical knowledge can treat the cases, but they couldn't be more wrong.

Dermatology is very challenging. Most of our diagnosis rests on clinical observations and clues. So, while everyone has a look at a clinical picture, we on the other hand observe and try to come to a diagnosis, without any investigations providing prompt results at most times - this proves to be challenging.

Another ill-informed concept amongst the medical fraternity and general population is that our specialty deals with 'TRIVIAL' cases. Only if you have ever had sleepless nights due to recurrent attacks of urticaria or intractable chronic itch, would you understand the triviality of the matter. Or, a patient of Pemphigus, with his skin peeling off at the slightest touch, or someone with Psoriatic Erythroderma, who has his whole body covered with scales, can validate the gravity of their condition. And the list is exhaustive. Not so 'TRIVIAL' now, is it?

"No Emergencies in Dermatology" - a very common misconception. It is so common that even I was under the false impression that I would be having peaceful nights. Into the 3rd year of my residency now and I am still attending emergency calls from the Casualty. It opened my eyes to the world of Dermatological Emergencies - a thriving whole subspecialty in itself with cases ranging from Angioedema to Drug reactions, from Erythroderma to Pustular Psoriasis and so on. Instances of emergencies in dermatology are far less frequent, but that doesn't make them any inferior or different from other specialties.

Dermatology is boring - or is it? I was apprehensive about it too. I was pleasantly surprised when I was proven wrong about it. The sheer variety of cases and the variations in individual cases is astounding. Dermatopathology, Paediatric Dermatology, Dermatological Therapeutics are an important aspect of Clinical Dermatology and much sought after Subspecialties. Another exciting subspecialty is dermatosurgery and aesthetics, where there are procedures ranging from simple techniques like chemical peels, ILS, and excisions to more complex procedures in Cutaneous surgery.

Dermatology combines a myriad of disciplines – Pathology, Microbiology, Pharmacology, Paediatrics, Internal Medicine, Surgery to name a few. One can say Dermatology is the perfect combination of Medicine and Surgery, where you need the diagnostic acumen of a physician along with the precision of a surgeon's hands. It allows you to think and process while using scalpels, sutures, cautery machines etc. It's the best of both worlds.

If interacting with people is your cup of tea, you will get to meet and look after patients of all ages – from infants to children to teenagers to adults to elderly – each with their own unique set of dermatological conditions. It's like being a family practitioner without the demands and risk. It has the human connection many of us seek and fail to find in our entire life - something which we tend to overlook, but it's the one thing that led us to become doctors in the first place.

With Dermatology, one can have a fulfilling work-life balance. Now let's face it - this is the reason why most top rankers opt for Dermatology. There's no denying the fact that most of the current generation of dermatologists, including the aspiring ones, have this factor on near about the top of their priority list. With the general perception of public towards doctor turning hostile by the day, who would blame them for wanting a life of peace, security and fulfilment? One can work full time and still be there for other personal engagements - this career flexibility and professional latitude are unique privileges.

Contrary to popular perception, dermatologists actually contribute to saving lives. Without us, there would a whole section of the society suffering from seemingly 'Trivial' diseases making their lives difficult. There are a lot of dermatological conditions out there which could be fatal without proper care and treatment. We might not be treating internal malignancies or other systemic diseases, but we can help in the diagnosis when the patient presents to us with cutaneous features.

Dermatology is a relatively happy specialty. You will be happy practising it and you can make your patients happy – most of the time. If you find the right temperament, most of the patients will be walking out of your chamber smiling. And in this day and age, happiness is a priceless commodity. With that, I am glad that I chose Dermatology, despite everyone advising me against it. I am happy and satisfied with my choice of work and can't imagine myself pursuing any other specialty. It lets me Think – Touch – Cut – Connect, and I connect with my specialty. ■

पूर्वोत्तर derma

CUTANEOUS RADIATION SYNDROME: AN OVERVIEW

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The infamous "CHERNOBYL" nuclear plant disaster occurred in the month of April 1986 . In a bid to explore the lesser known facts and details of the events that unfolded prior to this tragedy and in its aftermath, a historical drama television miniseries named "CHERNOBYL" was aired on HBO recently. The 5 episode long series ignited in me the curiosity to explore and learn about the ACUTE RADIATION SYNDROME(ARS) in general and CUTANEOUS RADIATION SYNDROME(CRS) in particular.

CUTANEOUS RADIATION SYNDROME (CRS) is one of the four sub-syndromes of ACUTE RADIATION SYNDROME(ARS). CRS is the clinical continuum of the pathophysiological reactions of the skin and skin appendages to significant levels of ionizing radiation. If the skin has been exposed to whole or partial body radiation which penetrates into the deeper tissues (eg. gamma & neutron), there are more chances of causing the other 3 sub-syndromes of ARS (hematopoietic, gastrointestinal, and neurovascular). However, exposure of large areas of skin to high energy beta radiation causes mainly major skin effects called CRS, since it usually doesn't penetrate into the deeper tissues. After the Chernobyl nuclear reactor accident, beta burns were the primary cause of death in a number of patients, increasing the morbidity and mortality of ARS; especially when skin injury exceeded 50% of the body surface area. There are four phases of CRS : prodromal, latent, manifest illness & recovery (with/without chronic or late effects). The prodromal stage is marked by erythema, edema, pruritus, increased skin temperature and dysaesthesias. The length of the latent phase is variable and can be longer with lower dose of radiation exposure. The prodromal symptoms may stabilize or slightly improve during the latent phase. The manifest illness phase can be divided into an early and a late phase. The early phase is marked by the second wave of erythema, swelling and edema of skin and subcutaneous tissues, corresponding to the renewal of epidermal cells. In the late phase, there may be dry desquamation, or transition into late effect phase without any other symptoms or with symptoms like blistering, moist desquamation, ulceration/necrosis, or transition into late effect phase after 2 weeks with additional symptoms (e.g epilation or onycholysis). Thereafter, the possible chronic or late effects may be epilation, which is transient or permanent depending on dose, pigment changes, onycholysis, fibrosis, telangiectasias, skin atrophy and cancer. However, many of these changes can take years or even decades to occur.

Specialized tests may be helpful in managing selected cases with poorly characterized or severe skin injury which include sequential color photography to document skin changes over time, ultrasonography and/or MRI to evaluate injury depth, thermography which is based on the fact that tissue necrosis lowers skin temperature while inflammation raises skin temperature, capillary microscopy to assess severity of injury by viewing vessels in dermal stratum papillae, profilometry to evaluate changes to skin surface and histology/biopsy.

The general considerations for acute medical management may include maintaining wound cleanliness and debridement, fluid replacement, management of pain, management of pruritus, topical anti- inflammatory therapy (e.g. corticosteroids), anti-microbial prophylaxis and therapy, inhibitors of proteolysis, growth factors to enhance granulation and re-epithelialization, stimulation of local blood supply (e.g. pentoxifylline).

The management of severe subacute or chronic radiation-induced skin injuries that heal poorly or fail to heal may include medical therapy like anti-coagulation to prevent clotting in dermal and subcutaneous vessels, anti-inflammatory therapy, physiotherapy-range of motion exercises for joints and soft tissues after skin injuries that have re-epithelialized & surgical therapy like local excision with or without grafting for closure with/without amputation (e.g., digits, limbs).
CRS complicates management and recovery from other ARS sub-syndromes. CRS (and loss of intact skin barrier) can result in major microbial infection, bleeding, fluid loss & pain. CRS can be prognosticated based on a grading system.

- Grade 1 is mild where recovery is likely.
- Grade 2 is moderate in severity and recovery is likely without any significant deficit.
- Grade 3 is severe where recovery is likely with deficit.
- Grade 4 is critical and serious deficit is seen which needs reconstruction in appropriate setting.

Overall, CRS poses a great challenge with regard to its management and different branches of clinical medicine must work in close coordination in order to manage the various complications that may arise out of the ARS in general and CRS in particular. As far as CHERNOBYL is concerned, the long term effects of this tragedy are still felt after 33 years of the accident. After this tragedy, the lives of the victims and their descendents changed forever. ■

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THE artist GALLERY

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"CHEMOTHERAPY ASSOCIATED SUPRAVENOUS HYPERPIGMENTATION"

A CASE REPORT

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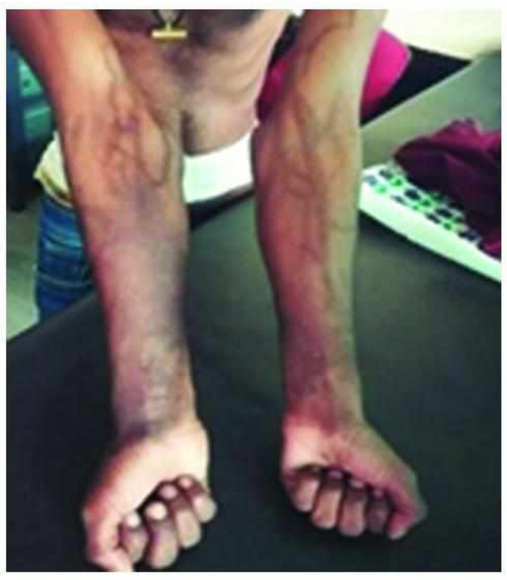
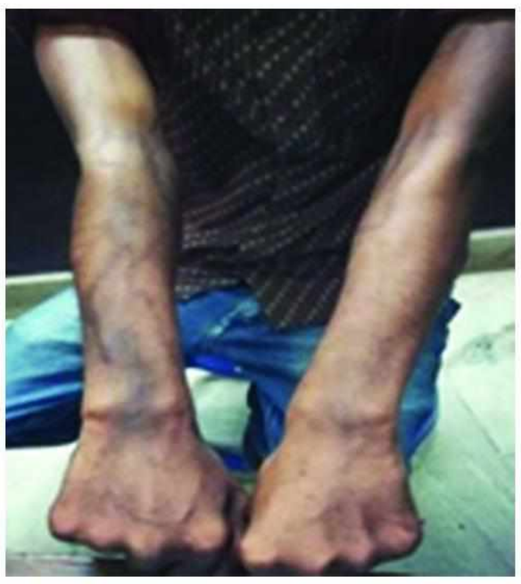
INTRODUCTION

The term Serpentine supravenous hyperpigmentation(SSH) was first used by Hrushesky .This condition is presented with increased pigmentation of the skin immediately overlying the venous network following intravenous infusion of 5-fluorouracil. This phenomenon has also been observed in individuals treated with other chemotherapeutic agents like vinorelbine , fotemustine and docetaxel as well. This condition is benign and self limiting.

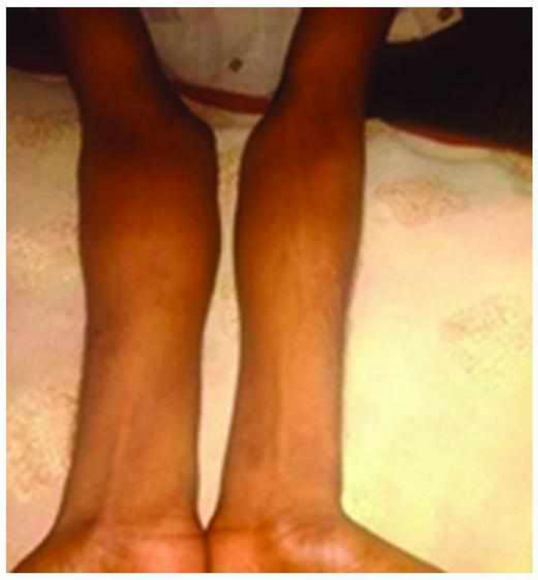
CASE REPORT

A 19 year old male patient diagnosed with Colon adenocarcinoma in 2018. He underwent a course of chemotherapy through a peripheral access which included Inj oxaliplatin , Inj Leucovorin and Inj 5-Fluorouracil. There was no cutaneous adverse effects during the first 4 cycles of chemotherapy.
Following the 5th cycle, the patient noticed asymptomatic pigmentation retracing the venous streak in the upper limb.

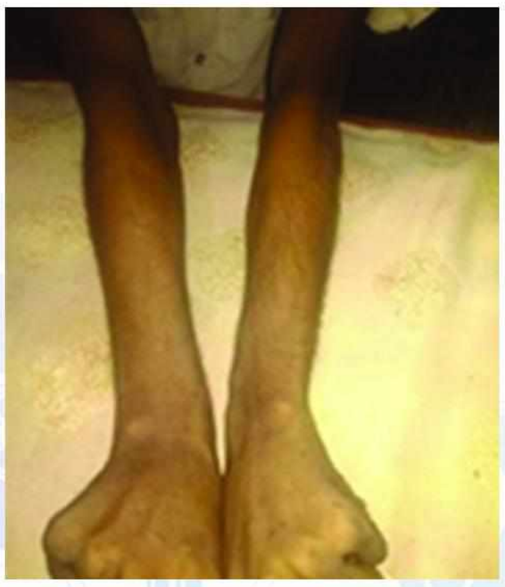




Clinical examination revealed linear streaks of hyperpigmentation along the course of superficial veins of bilateral upper limb extending from the dorsum of the hand to the shoulder . The veins underlying the pigmented streaks were neither tender nor thickened. There was no regional lymphadenopathy . Examination of palms was unremarkable. No erythematous changes or itching was noted. There was no apparent leakage of medicinal agents in surrounding skin. There was no history of extavasation or phlebitis preceeded the hyperpigmentation.



For this patient , no other medication was prescribed other than topical emollient. Substitution of 5-Fluorouracil with capecitabine was advised. By the end of 4 weeks, we noticed remarkable reduction in hyperpigmented lesions. 3 months later, the complication completely resolved.

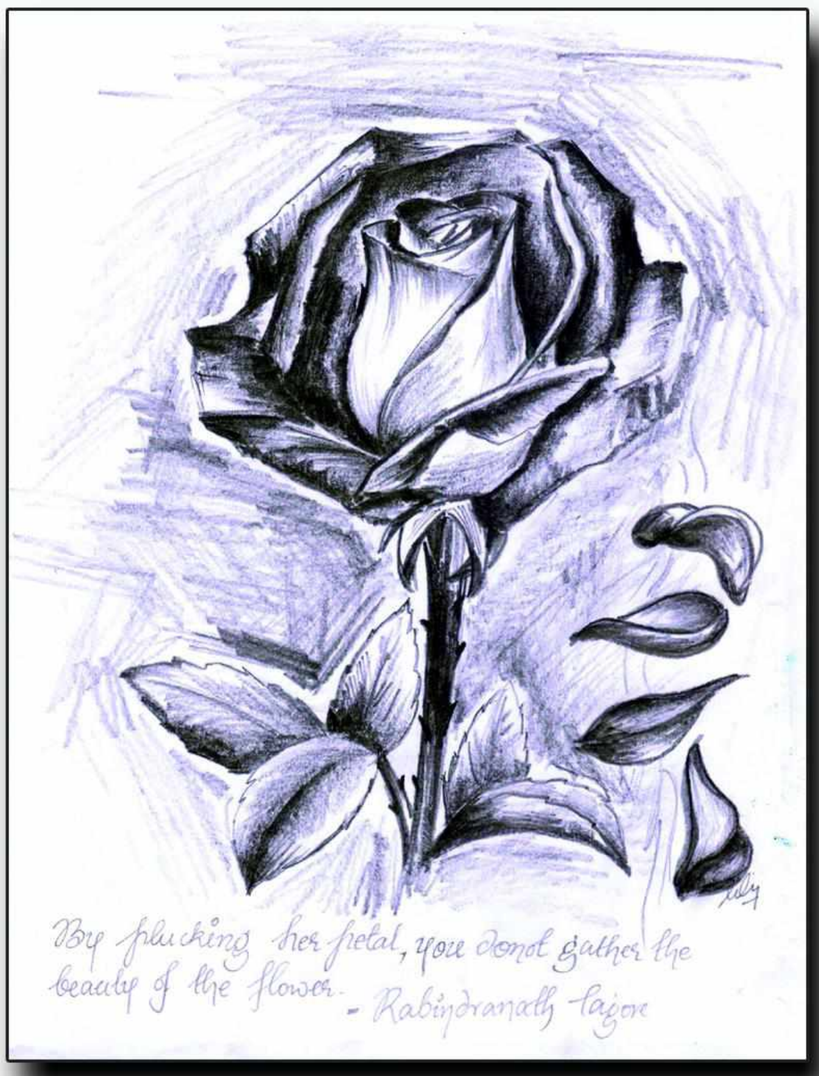


DISCUSSION

Schulte-Hermann et al concluded that although pigmentary changes secondary to chemotherapy are frequent , this particular Serpentine/linear supravenous hyperpigmentary changes are uncommon. The exact mechanism of pigment induction is unknown ,but some hypothesis suggested that these cytotoxic drugs cause loss of endothelial integrity, which permits the leakage of agents from vessels to the overlying epidermis where it interferes with melanogenesis- thus resulting in hyperpigmentation.

No specific treatment is recommended. Pigmentation promptly subsides once the offending drug is stopped.

THE artist GALLERY



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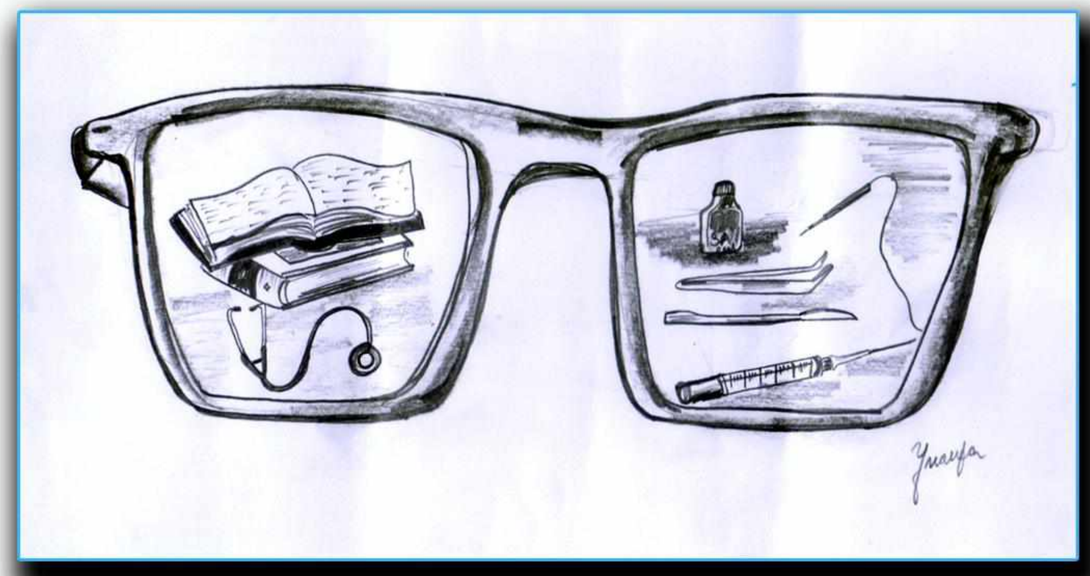

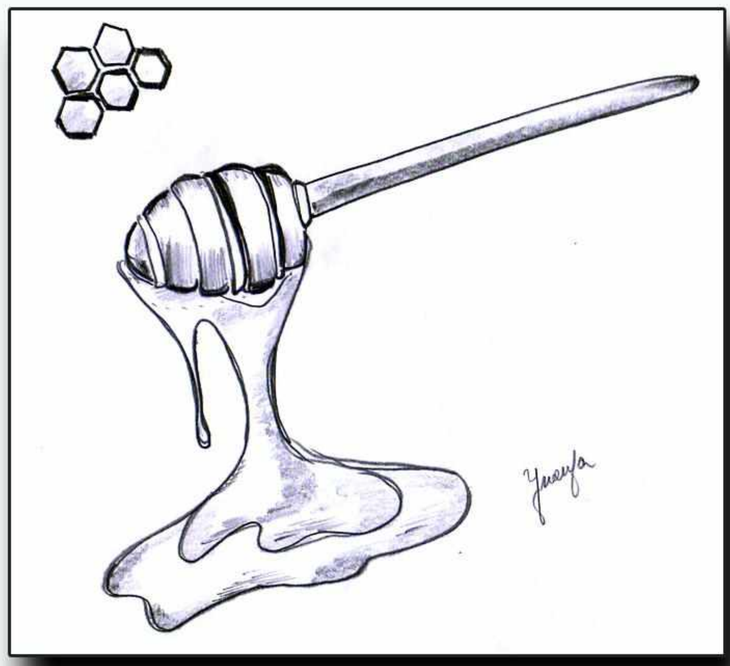

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CROSSWORDS

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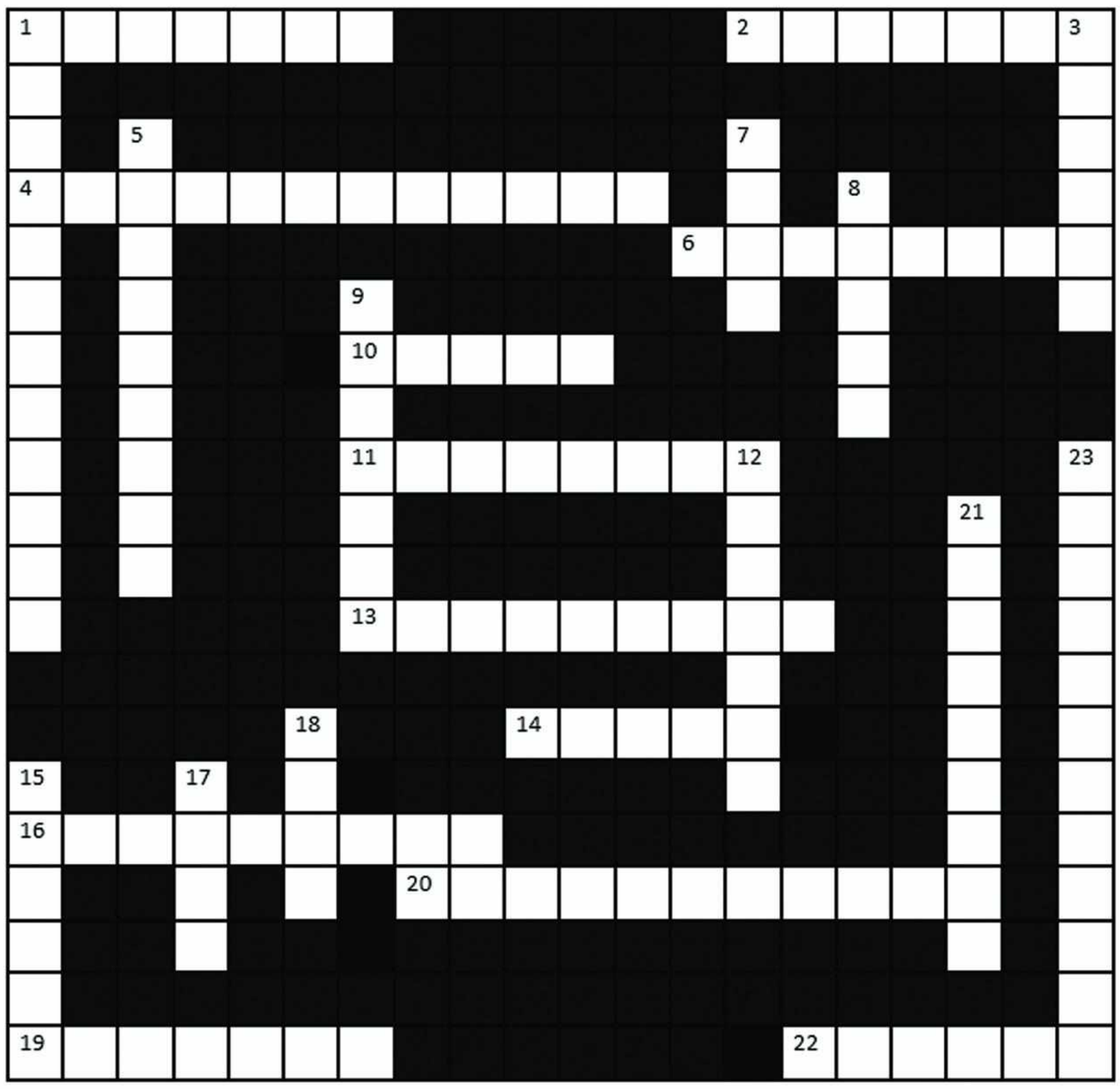
Hints



ACROSS (Diseases and syndromes)

1. A sparing phenomena over the interscapular area, called the Butterfly sign, is seen in this condition.
2. A syndrome comprising of livedo racemosa, cerebrovascular lesions and acrocyanosis.
4. A syndrome, aka cutis hyperelastica where Gorlin's sign is found.
6. An area of hypomelanosis which develops around a central cutaneous tumour.
10. A syndrome and an acronym describing the violaceous lesions and lymphadenopathy in plasmacytoma .
11. A mycobacterial lymphadenitis with discharges smelling of stale beer.
13. A disorder of pigmentation and a common feature in a number of inherited and acquired disorders - Xeroderma pigmentosa, Neurofibromatosis, Progeria etc.
14. A form of intraepidermal SCC in-situ which was initially thought to be due to exposure to arsenic.
16. A disorder commonly affecting females at or soon after birth presenting with subcutaneous atrophy over the extremities.
19. AKA Couperose in French, UV light exposure and Demodex mite proliferation are thought to be the causative factors.
20. Caused by Erysipelothrix rusiopathiae, commonly affecting butchers, cooks, fishermen and famers over the exposed areas.
22. A disease which is a cutaneous marker of internal malignancy - thrombophlebitis of thoracic or epigastric veins, usually unilateral.

DOWN (Drugs and signs)

1. A macrolide derived from Streptomyces, most effective in the treatment of steroid induced perioral dermatitis.
3. Deficiency of this micronutrient causes neurological and gastrointestinal symptoms along with fixed skin eruption resembling sunburn.
5. One of the common cutaneous adverse effect of this drug is flagellate pigmentation.
7. A histopathological sign found in actinic keratosis and a trichological sign in kwashiorkor.
8. A sign for exact localisation of tenderness in Glomus tumor.
9. A sulfa drug which is also used for treatment of brown recluse spider bites.
12. A sign found in keratosis pilaris- strands of keratin glinting in tangential incident light.
15. A sign found in leukemia cutis, xanthogranuloma, mastocytisis, Langerhans cell histiocytosi.
17. A sign which describes a sparing phenomena in face seen in exfoliative dermatitis.
18. 40% concentration of this drug is used for chemical nail avulsion.
21. Another name of Hydrocortisone when it was first isolated and later patented in 1936.
23. A sign which describes petechial spots found in Rubella and sometimes in Infectious mononucleosis- an enanthem.

ANSWER IS IN PAGE NO. 22

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EPONYMS OF HUTCHINSON

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Sir Jonathan Hutchinson, was a well known English surgeon, ophthalmologist, dermatologist, venereologist and pathologist.
Here are some of the accidental discoveries in the field of dermatology.

He believed that illustration was a necessary adjunct to clinical observations. So, he employed an artist to visit the wards and paint pictures of skin museum for his collection of drawings, illustrations and wax models depicting pathological and dermatological conditions.

His intense activity and involvement in various medical specialties was unwearying and therefore, numerous eponymous terms were named after him.
Hutchinson has his name attached to the following entities -

1. ***HUTCHINSON'S EYE SIGN –*** It is the presence of vesicles on the tip of the nose or nasal mucosa on the ipsilateral side of herpes zoster ophthalmicus infection, which is indicative of involvement of the nasociliary branch of the ophthalmic division of trigeminal nerve.

2. ***HUTCHINSON'S NAIL SIGN –*** It is the periungual extension of brown – black pigment from the nail bed and nail matrix onto the surrounding tissues, which usually occurs during the radial growth phase of subungual melanoma.

3. ***HUTCHINSON'S TRIAD –*** It is characterized by the presence of interstitial keratitis, VIII nerve deafness and 'Hutchinson's teeth' (teeth that are smaller and more widely spaced than normal and have notches on their biting surfaces). These are the features of late Congenital Syphilis.

4. ***HUTCHINSON'S MASK –*** It is a sensation often associated with tabes dorsalis in which the face feel as if it is covered with a mask or cobwebs.

5. ***HUTCHINSON'S FACIES –*** It is a facial appearance involving dropping eyelids and immobile eyes in external ophthalmoplegia. This sign is associated with Neurosyphilis.

6. ***HUTCHINSON'S MELANOTIC FRECKLE –*** It is known as Lentigo maligna. It is a precursor to lentigo maligna melanoma. Here, malignant cells are confined to the tissue of origin, the epidermis, hence it is often reported as 'in situ melanoma'.

7. ***HUTCHINSON'S SUMMER PRURIGO –*** It is known as Actinic Prurigo. It is an intensely itchy skin condition caused by an abnormal reaction to sunlight. It presents with small, intensely itchy papules on sun-exposed sites, typically appear hours or days after exposure to UV light.

8. ***HUTCHINSON'S DEHYDROSIS –*** It is also known as chiropompholyx, refers to chronic hand and foot dermatitis, characterized by the presence of numerous vesicles and multilocular bullae frequently on the hand than on foot.

9. ***HUTCHINSON'S PERNIO –*** It is known as Chilblain Lupus, a localized inflammatory lesions on the acral skin, which occurs as an abnormal reaction to cold in susceptible individuals.

10. ***HUTCHINSON'S ANGIOMA –*** A skin disease which is characterized by minute vascular ectasia arranged in serpiginous fashion.

11. ***HUTCHINSON – BOECK DISEASE –*** It is now known as Sarcoidosis, a multisystem granulomatous disease of unknown aetiology that mainly involves the lungs, mediastinal and peripheral lymph nodes, eyes and skin.

12. ***HUTCHINSON- GILFORD PROGERIA SYNDROME –*** It is popularly known as Progeria, an extremely rare genetic condition characterized by growth retardation with premature and accelerated ageing.

13. ***HUTCHINSON- WEBER- PEUTZ SYNDROME –*** It is now known as Peutz-jeghuer syndrome. Hutchinson emphasized the spots around the mouth and on the buccal mucosa but didn't recognize the association of intestinal polyps. But he had written on intussuception which is a major way, in which jejunal polyps are manifested. ■

FOOD EPONYMS IN DERMATOLOGY

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"Signs" in the medical lexicon means a physical finding observed by a physician. These signs help us remember and visualise the characteristic findings in a case, especially when it is related to different items in our food menu. Listed below are a few signs straight out of our kitchen-

Fruits

- Apple jelly nodules: Diascopy finding in granulomas of lupus vulgaris.
- Banana bodies: Pathologic sign of ochronosis.
- Black berry stomatitis: seen in Paracoccidioidomycosis.
- Blueberry muffin lesions: seen in congenital Cytomegalovirus infection.
- Cherry angiomas: Most common cutaneous vascular proliferation.
- Milian citrine skin: seen in Photoaging.
- Mulberry like erosions: Oral manifestation in Paracoccidioidomycosis.
- Mulberry molars: seen in congenital Syphilis.
- Peau d' orange: occurs due to dermal edema.
- Strawberry gums: seen in Wegener's granulomatosis.
- Strawberry hemangioma/strawberry nevus: Another name for infantile hemangioma.
- Strawberry tongue: seen in Scarlet fever and Kawasaki disease.

Vegetables

- Bean bag cells: Histopathological finding in Cytophagic histiocytic panniculitis.
- Bean syndrome: other name of Blue rubber-bleb nevus syndrome.
- Garlic clove fibroma: Also known as Acquired periungual fibrokeratoma.
- Nutmeg grater appearance: seen in Pityriasis rubra pilaris.
- Tomato catsup fundus: due to Choroidal angiomas- may be seen in association with facial port-wine stain and Sturge-Weber syndrome.
- Onion skin cysts: Histopathological picture seen after injection of bulky oils.

Beverages

- Champagne bottle leg: seen in Chronic lipodermatosclerosis
- Port wine stain: Also known as Nevus flammeus.
- Stale beer smelling discharge: seen in Scrofuloderma.

Spices

- Cayenne pepper spots: seen in Progressive pigmented purpuric dermatosis.
- Salt and pepper fundus: Syphilitic stigmata due to scarred choroiditis and optic atrophy.
- Oil spot: It is seen in patients with psoriasis.

Breakfast

- Breakfast, lunch and dinner sign: Clustered linear flea bite reactions.
- Café-au-lait macules: seen in Neurofibromatoses.
- Corn flake sign: seen in Kyrle's and Flegel's disease.
- Fried egg appearance: seen in Atypical nevi.
- Sandwich sign: Histopathological sign of dermatophytosis.
- Sausage finger: seen in Psoriatic arthritis with tenosynovitis.
- Spaghetti and meat balls: seen in KOH mount preparation of scales in Pityriasis versicolor.
- Toasted skin syndrome: seen in Erythema Ab Igne.
- Wafer like scales: seen in Pityriasis lichenoides chronica, clear cell acanthoma.

Sweet tooth

- Doughnut sign: seen in Scleromyxedema.
- Honey comb atrophy: seen in Atrophoderma vermiculatum.
- Honey coloured crusts: seen in Bullous impetigo.
- Sweet syndrome: also known as Acute febrile neutrophilic dermatoses.

CHROMOBLASTOMYCOSIS

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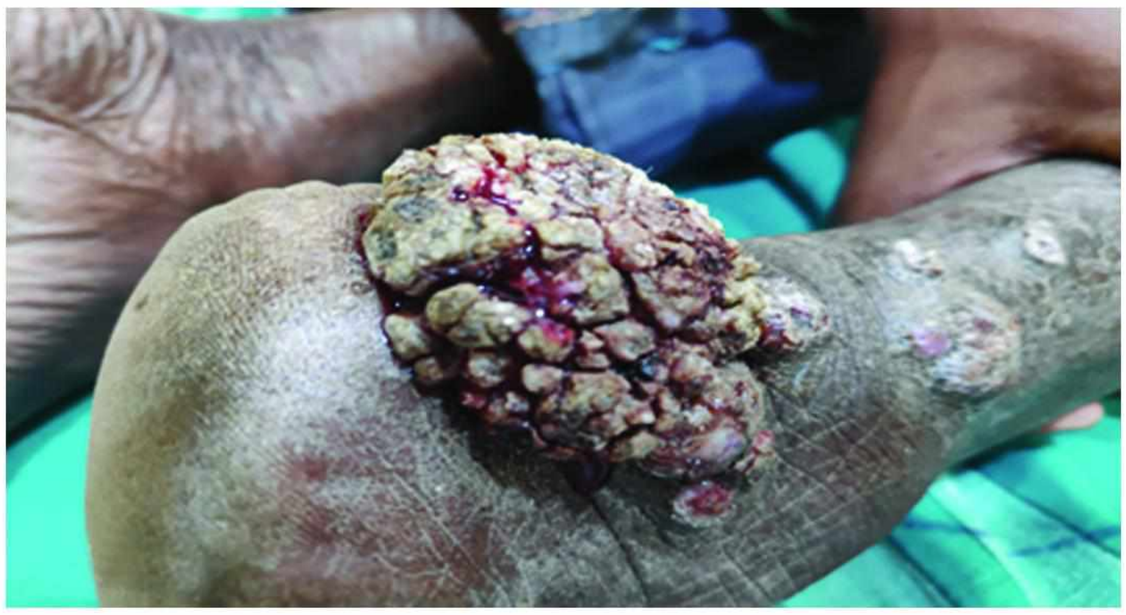
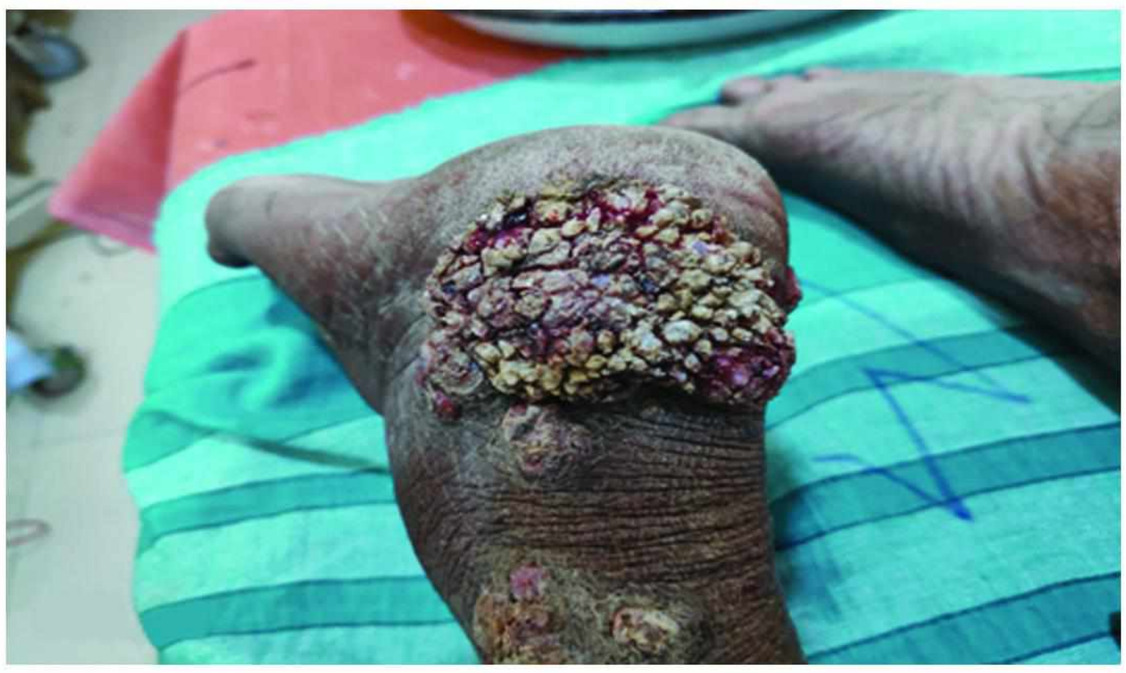
A 45 year old male patient presented to the Dermatology OPD at Silchar Medical College and Hospital with the chief complaint of a fungiform growth for 9 months, which was insidious in onset, progressively increasing in size, not associated with any significant symptoms.

On examination- there was a verrucous plaque present near the heel of right foot.



Biopsy was carried out after taking an informed and written consent. Histopathological examination confirmed the patient to be a case of chromoblastomycosis.



What is chromoblastomycosis?
Chromoblastomycosis is a chronic granulomatous infection, usually occurs on the exposed areas and characterized by the development of warty plaques, nodules or cauliflower-like lesions, which may ulcerate.

What causes chromoblastomycosis?
The principal etiologic agents are:

- *Phialophora verrucosa*
- *Cladophialophora carrionii*
- *Fonsecaea pedrosoi*
- *Fonsecaea compacta*

How does the patient present with chromoblastomycosis?

- The lesion is frequently seen on exposed sites which are prone to trauma.
- It begins as a warty papule and slowly enlarges to form a thick hypertrophic, verrucous plaque. Some lesions may have central atrophy and scarring and are usually painless.
- Black dots may be seen on the surface of the plaques.
- Satellite lesions develop due to autoinoculation by scratching. Lymphatic extension may also occur.

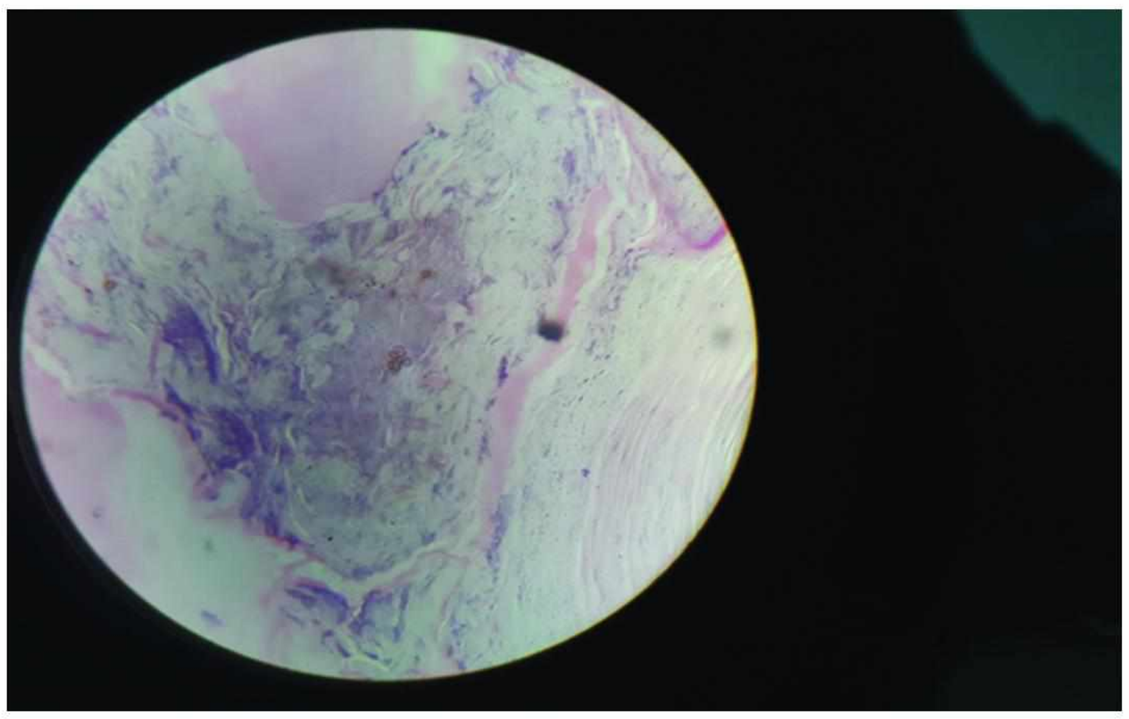
Long-standing lesions may result in lymphedema and elephantiasis due to lymphatic spread.

How can we investigate a case of chromoblastomycosis?
To start with, all routine investigations are carried out.
There might be eosinophilia.
To confirm the diagnosis, a histopathological examination of the tissue biopsy specimen is usually done. Culture of the fungus on a suitable media also confirms the diagnosis.

What findings are expected on histopathological examination?

- The dermis shows foreign body granulomas composed of epithelioid cells, lymphocytes, histiocytes and Langhans giant cells along with eosinophils, some neutrophils and plasma cells. Isolated microabscess formation are seen.
- The epidermal reaction is characterized by acanthosis, elongation of rete ridges, hyperkeratosis and parakeratosis.
- Some of the elongated rete ridges surround clusters of fungi, abscesses and granulomas.

The fungi are visible as dark brown, thick-walled, spherical bodies, 5–15 µm in diameter, with thick, planate, septal walls (sclerotic bodies/muriform bodies)



What is the treatment of chromoblastomycosis?
First line

- Itraconazole 100–200 mg daily until clinical recovery

Or

- Terbinafine 250 mg daily until clinical recovery

Second line

- Heat application to induce shrinkage or cryotherapy

CROSSROADS

"Struggling to decide what to do after graduation is, and always will be a sort of rite of passage to the next phase of your life"

Dr. Saloni Katoch
Consultant Dermatologist,
Dr. KN Barua Institute of Dermatological Sciences,
Guwahati, Assam.

Post residency can be a confusing phase with the "what next?" question always hovering over our heads. With so many options available nowadays, sharpening and learning new skills after post-graduation has become more refined and simpler. In my opinion, in the first few years post residency, we are like sponges, learning and imbibing from others and our own experiences. Persistence, patience and tenacity are important to work through days when the mind is flooded with questions and the professional front seems chaotic. One's area of interest may develop during post-graduation or gradually, even years after residency. So, where should one start?

Begin this journey by taking a long holiday after your post-graduate exams because not only do you deserve it but you have earned it by burning the midnight oil and studying tirelessly. I came back after a refreshing holiday only to find most of my friends either placed in a medical college or working with a senior dermatologist or pursuing a fellowship. And there I was still thinking of what to do next - a little nervous but optimistic. Just like all the residents, I too had numerous doubts and questions like-

- Should I join a medical college?
- Should I work with a senior dermatologist?
- Should I pursue a fellowship?
- Should I join a commercial cosmetic chain of clinics?
- Should I join a corporate hospital?
- Should I start my own clinic?

1. Before answering the above questions, it is very important for you to talk to and discuss with your seniors, teachers and friends because nothing can match experience and seasoned advice.

2. You need to prepare a Curriculum Vitae (CV) with details about education, achievements, publications and presentations. Standard format for the above is available online and should be submitted to clinics or hospitals that you are interested to join. Your CV should reflect you on the paper.

3. If one has the answers to the above questions then the next step becomes easier; if not, then one must remember that each and every experience after residency will be helpful in the future.

4. Do make a profile on the online job portals - they will give you an idea about pay packages and placements available in your region or areas of interest. A lot of institutions and corporate chains recruit dermatologists through these online portals.

5. If one has an academic bend of mind and likes teaching, joining an academic institution as a senior resident would be helpful to explore your area of interest. Some institutions have a bond and do not allow private practice for up to a few years afterss joining. Research oriented activities are done more often in medical colleges and have an added advantage of exposure to writing articles and publishing them. Keep your eyes and ears open for announcement of vacancies in medical colleges that you are interested in joining. I personally like teaching and did apply in two medical colleges. Both had already recruited senior residents, while the others were too far away for me to commute in the Bengaluru traffic.

6. Working with a senior dermatologist is one of the best things to do. Not only does one learn soft skills of patient management and counseling, but also learn a lot about clinic establishment and its functioning. I had the opportunity to work with Dr. MK Shetty and joined under him at Dr. Shetty's aesthetics. Just sitting with Sir was a lesson in talking and most importantly listening to the patient. My cosmetic and aesthetic dermatology skills were carefully monitored and it improved. My first exposure to a wide variety of lasers apart from the IPL was while working with Sir. While working with a senior dermatologist, the main aim is to learn, sometimes unlearn and also relearn. Don't hesitate to approach senior doctors and express your interest in working with them and learning.

7. Fellowships are also an excellent way of learning and training in areas that one is interested in. University recognized fellowships are usually of one-year duration. A theory and practical exam is conducted at the end of the training period before the fellowship is awarded. RGUHS (Rajiv Gandhi University of Health Sciences, Bengaluru) recognized fellowships in dermatosurgery, paediatric dermatology and aesthetic dermatology are available at Bangalore Medical College, St. John's Medical College, Venkat Center for Skin and Plastic Surgery and CUTIS Academy of Cutaneous Sciences. The most recent fellowship to have started is in Trichology at Hairline Clinic. Apart from the above, training courses and observerships are also offered by private clinics and institutes by senior dermatologists all across the country.

IADVL observerships are also available for post residency candidates. One needs to apply for them once the application forms are out on the IADVL website. Details of the above are available on https://iadvl.org/. I had the opportunity to learn from Dr. Venkataram Mysore at the Venkat Center for Skin and Plastic Surgery, Bengaluru under the IADVL observership program. It is a good learning experience, especially for residents who have just finished their post-graduation. Fellowships are also offered by ACSI (Association of Cutaneous Surgeons of India) to its members, details of which are available on https://www.acsinet.net/. The following article gives a good understanding of opportunities available for residents in India: Kolalapudi SA, Valia AR, Pandhi D. Clinical training and research opportunities for dermatology residents in India. Indian Dermatol Online J 2018; 9:231-3. Dermatologists interested in dermatopathology can go through the following article for training programs available in India and abroad: Laskar S. Training avenues in dermatopathology for an Indian dermatologist or pathologist. Indian J Dermatol Venereol Leprol 2018;84:506-9.

8. A lot of commercial cosmetic and aesthetic clinics have opened across the country. These usually have their own training modules before one can start working with them as a consultant. They train dermatologists especially recent pass outs in aesthetic and cosmetic dermatology procedures. One can enroll with them and also practice clinical dermatology, maintaining a good balance between the two. I have never worked in a commercial cosmetic chain and my knowledge about their working is largely based on feedback from friends and colleagues who have been attached to them. Some of these chains have targets to meet and can sometimes pressurize young dermatologists into prescribing packages or procedures, something that is ethically incorrect and must not be done. It is important to take the learning and positives from these centers so as to apply them into your future practice.

9. Corporate hospitals usually require a few years of experience before one can join as a consultant. The working environment is disciplined and multidisciplinary approach to a case is much easier just like in a medical college. One also feels the heat as patients have appointment slots, are demanding and can also complain if not satisfied with the service. I worked in Columbia Asia hospital, Bengaluru as a consultant for a year and a half and primarily developed my own way of patient management during these formative years. I also learnt a lot from our senior consultant Dr. PS Murthy who guided me with ease through complicated cases and inpatient management.

10. Only a few tread upon this last path of opening a clinic immediately after passing out. Looking for an ideal place, finance management, designing, recruiting staff, building a practice and maintenance are few of the many things that one needs to plan. A few of my friends have done this and are doing well in their respective cities. Will power and determination is the key in starting and running a successful private clinic.

Drawing this long article to an end, you may have noticed that there is never a perfect way of doing or learning something. You may have planned an academic route but destiny may have other plans. Today I practice as a consultant with an academic bend of mind in a private clinic. I hope my experience will help young residents in their decision-making process. Learning is always by trial and error. Identify skills that you want to train in or acquire and choose a course that suits your needs. Whatever option or options one chooses, the experience will always help you in your practice. Keep yourself updated with the recent advances and publish when you can. "There are no secrets to success. It is the result of preparation, hard work and learning from failure" – Colin Powell. ■

CROSS WORDS

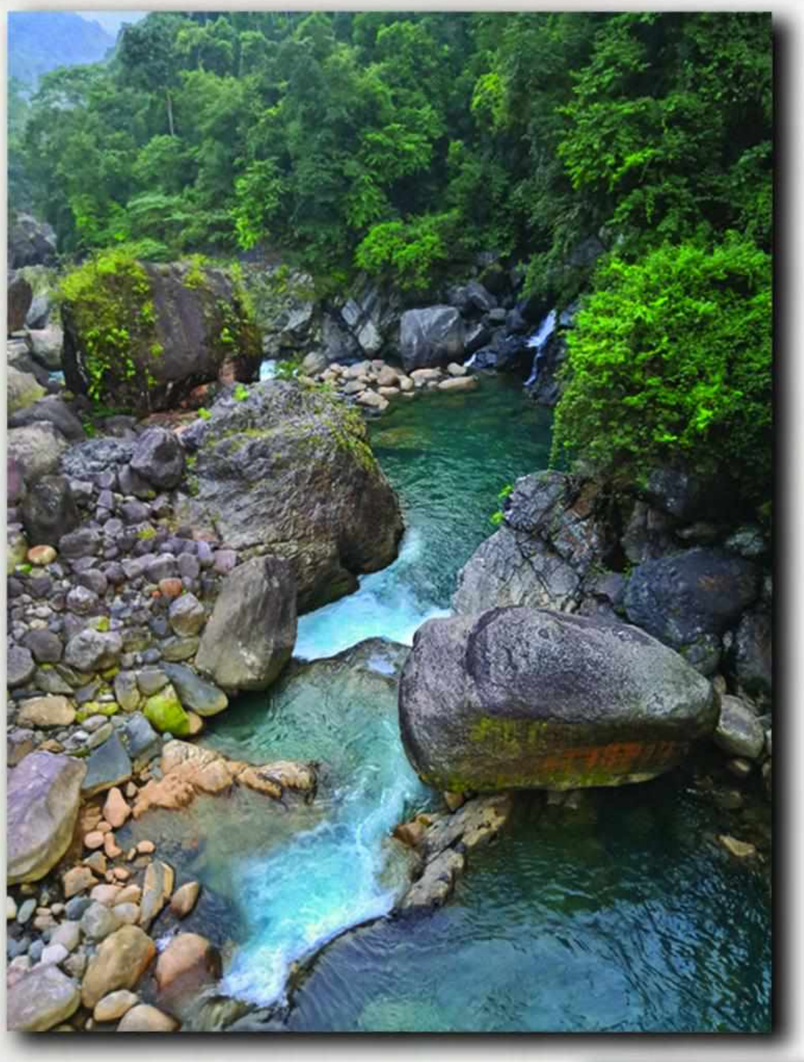
ANSWERS

Across-

1. Prurigo 2. Sneddon 4. EhlersDanlos 6. Halonevi 10. AESOP 11. Scrofula 13. Ephelides 14. Bowen 16. Acrogeria 19. Rosacea 20. Erysipeloid 22. Mondor

Down -

1. Pimecrolimus 3. Niacin 5. Bleomycin 7. Flag 8. Loves 9. Dapsone 12. Antenna 15. Darier 17. Nose 18. Urea 21. CompundF 23. Forschheimer



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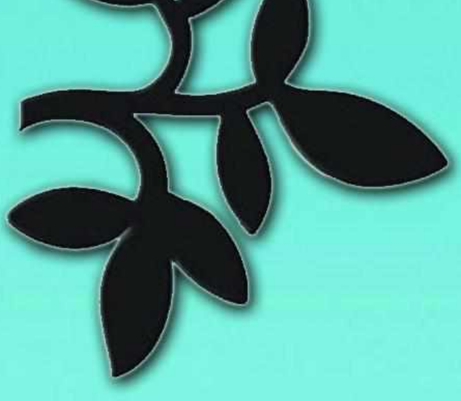

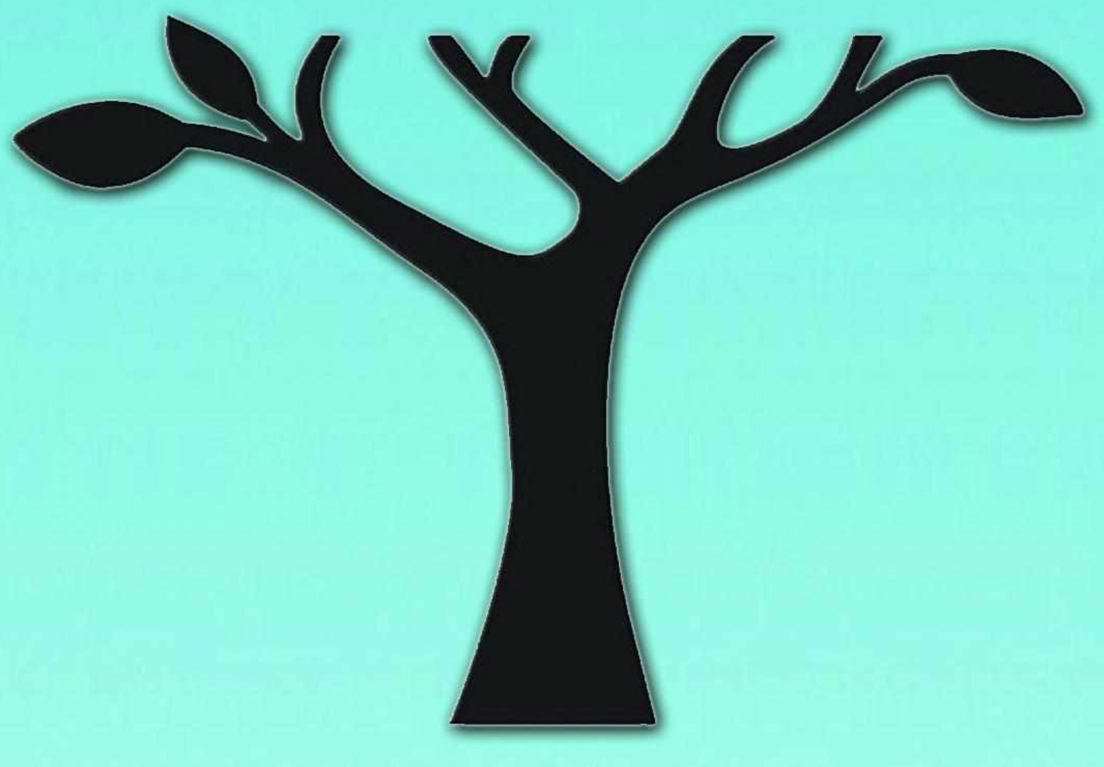

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