YUVADERMA
E-BULLETIN

Septmber 2018, Vol. 1, Issue-6

THE ESSENCE

The artwork reflects the essence of Yuvaderma, where young minds are nurtured and moulded into the building blocks of tomorrow.

It represents the journey to the key of enlightenment and success via the road of knowledge, team work, dedication and perseverance.

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YUVADERMA E-BULLETIN

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आ नो भद्राः क्रतवो यन्तु वश्वित :

(ऋग्वेदः १-८९-१)

"Let noble thoughts come to me from all directions"

The above line from the Rigveda urges us to spread good thoughts and at the same time to have an open mind to accept thoughts of others.

I find these lines to be very accurate to the journey of Yuvaderma E-bulletin so far. Yuvaderma E-bulletin was sown as a novel idea of its own kind, first by any state, in 2016 by IADVL Karnataka. Now after 2 years and 5 editions, it stands strong, with its roots intact and branches spread out, and is setting an example to other state branches under IADVL.

There are many respected teachers and residents who have been behind the success story of this newsletter but this piece of literature has been the brainchild of my mentor and senior Dr. Saloni Katoch. She has always been there, and has been like a guiding light in my journey from Associate editor to Editor-in-chief of Yuvaderma E-bulletin. It has been a honour for me to take up this responsibility from the zealous, ever-helpful, twin-editors Dr. Shweta Bhadbhade and Dr Vaishnavi Gopal. It gives me immense pleasure to have got this oppurtunity to guide an enthusiastic, hardworking editorial team, comprising of residents from all over Karnataka; Dr. Gagana, Dr Pranami, Dr Priyanka, Dr Sanjay, Dr Shibani and Dr Shilpita, blessed with extraordinary thoughts and have let leash a smorgasbord of inventiveness.

We at the editorial board, are immensely grateful to Dr B.S. Chandrashekar, Dr Manjunath R and all present and past, respected executive committee members for giving us this platform to showcase our talents and for encouraging us in every path, in all possible ways.

This issue has assimilated knowledge and aptitude of a lot of young dermatologists from all over Karnataka. To start with, is a crisp article on male aesthetics which redefines cosmetology procedures to be gender inclusive. To counter this is an article on the first lady of Dermatology. The five pillars of success are passion, vision, hard work, dedication and sincerity – Man of vision- Dr B. S. Chandrashekar, unwinding the life of a leading clinician and academician. Followed by, a gripping debate between old school 'vs' new school teaching by two brilliant and proficient residents. Dermatologist = Good photographer, to prove this is the next section. "Topper Talks" a must read on how to be one, gold medalist herself shelling out all the secrets to us. This is followed by, something which will make you hungry! We next move on to, articles put in very innovative way to tease your brain, which makes dermatology more absorbing. Next we have, enthralling case

reports and spotter discussion, with the maestros Dr Balachandra S. Ankad and Dr Umashankar Nagaraju. We present to you, opinions of residents throughout Karnataka on various topics, collected as a poll, by conducting resident survey. Next in line is “Namma IADVL KN” which showcases various activities conducted by IADVL Karnataka. This is followed by a very apt and erudite article which highlights the meaning of various words which we use regularly in Dermatology (PS: It is important for viva too!!). Time to strike your souls, as we have a novel section in Kannada this time. “Vitiligo Day” was conducted with great success through-out Karnataka by IADVL-KN, it showcased exceptional contributions by residents towards Vitiligo Day posters and Vitiligo day Kannada script writing. Hold on your breath! We have included the articles and posters of winners here. We also have, art gallery and cartoon strips by our adroit residents present in various segments in this edition. Memes in Dermatology! Sounds catchy?? Turn the pages to know more…

This issue of ebulletin is as special to me, as every issue has ever been since the dawn. But, this 6th issue would always be very close to my heart, as this marks my debut as Editor-in-chief. We at the editorial, have put in lot of sweat, time and hardwork for this master-piece. The popularity of Yuvaderma E-bulletin is shooting up on every new issue. This issue saw tremendous contribution by residents, and we were overwhelmed with the response. The best part is, it included residents from all over Karnataka, which made evident that Yuvaderma E-bulletin has succeeded in its purpose now. The very talented, dedicated editorial board is already prepping up the next issue. Till then,

Hope you have a great read!

We are looking forward to your contributions for the next issue.

Thanks & Cheers!

Signing off…

Dr Preethi B Nayak,
Editor-in-chief,
Yuvaderma E-bulletin.

TREASURY

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- PIONEERS IN DERMATOLOGY - DR. NAVYA
- RENDEZVOUS WITH THE MAN OF VISION : DR B S CHANDRASHEKAR - BY DR. PRIYANKA KARAGAIAH
- A MOOT BETWEEEN OLD SCHOOL ‘V/S’ NEW SCHOOL - DR SHILPITHA SRINIVAS, DR SHIBANI BHATIA
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- ಕನ್ನಡ ವಿಭಾಗ :
  ತೊನ್ನು– ಕಳಂಕವಲ್ಲ?, ಕೇವಲ ವರ್ಣ ವ್ಯತ್ಯಾಸ... – ಡಾ. ಸಂತೋಷಿ ಎಂ. ನಾಯಕ್
  ಕತ್ತಲೆಯಿಂದ ಬೆಳಕಿನೆಡೆಗೆ ಸವಿತಾಳ ಪಯಣ, ಬಿಳುಪು ರೋಗದೊಂದಿಗೆ – ಮೇಘನಾ ಬಿ.ವಿ.
  ತೊನ್ನು : ಭಿತ್ತಿಪತ್ರ ಸ್ಪರ್ಧಾ ವಿಜೇತರು – ಡಾ. ವನಿತಾ ಎಂ.ಎಂ., ಡಾ. ನೀತು ಮೇರಿ ಗರ್ಗ್, ಡಾ. ಪಿ. ರಾಮ ಸುಶ್ರುತ್

PRESIDENTS PREAMBLE

Dear residents,

Greetings from the EC of KN IADVL. I know some of you are rearing to go to embrace the world of cutaneous sciences, some of you are dreaming of your own career in a few months from now, and few of you are enjoying the trans phase of these two ends.

As a young dermatologist you have a plenty of challenges coming in your way once you are successfully out of your post-graduation. I would like to share some of the basics to start and groom your practice. It is advisable to learn meticulous skills of clinical practice from one of your seniors. This is not possible by everyone. When you don't have such an opportunity then you are compelled to start your practice. For that, first of all, you should be committed to the place and time. Off late time is every one's priority and you should respect it. Place of your practice should be spot less and the person sitting in front of you has come for a need and to relieve his suffering, it's your bound duty to listen to him with full attentiveness and sincerity with an intention to get something from his history which may benefit your diagnosis or treatment. You should completely understand about your specialty with respect to its limitations, as you know diseases of Dermatology are chronic, recurrent and majority of them lack absolute cure. One should work towards benefiting the patients in some or the other way at every follow up. Your practice in the initial phase depends on the strength of the bond you develop with your patients by your communication skills, whatever be your intelligence and medals, awards, appreciations you got during your student days.

First consultation is like a spark plug of your bike, at first stroke you should be able to bring confidence in your patients which becomes foundation for long term relationship. Your way of examining the patient, talking to patient with good eye contact and comforting him with soft touch is crucial in establishing therapeutic relationship. Using dermascope or lens or torch to see the lesions, may not be required in every case but if done infuses confidence in your patients. Checking the documents even though irrelevant, explaining about disease, lending education handouts, clarifying prescription, legible hand writing, demonstrating the methods of application of medicines etc... are very important. You know when condition in question has protracted course you should be able to convey to the patient that you are continuously on his/her side at difficult times. Try helping

such patient with free samples that you keep in your chamber. The starting days of practice have to be treaded carefully as the biggest challenge is to get patients and the greatest task is to retain them. To accomplish this be honest, do not hesitate to get validation of your prescription by second opinion in chronic recurring dermatosis, choose procedures carefully and do not ever push procedures on patients. Patients condition should earn the procedure required. If the condition genuinely demands the intervention and then done success rate and satisfactory rate will be high on the graph. Try avoiding frequent follow ups by educating patients about their disease, it's chronic course and timely intervention at times of aggravation.

It is wise to start with low fees, low volume then to low fees to high volume and once established and put on decades of practice switch to low volume high fees to save time for family and relaxation. Now a days it is all the way digital, emphasize on modern technologies and avenues for your marketing alongside the well-established traditional ways but believe me at the end of the day it's true, nothing but true, "your own satisfied patients are your pro's" Do not get doomed in your practice, give some time for reading, research, publications and relaxing. Other things one should not forget is to get involved in association activities to help your colleagues and general public, remember this is your social responsibility and obligation.

Dear young turks, as I pointed out in the last issue you need to put your efforts to carve out much needed time from your routine for research and publications. The order of the day is to publish or perish, if you want to scale up in the academic ladder.

To have a successful carrier and happy life the MANTRA is to have patience, passion, perseverance and willing to do attitude and to overcome hesitancy, urgency, precipitancy, and impulsive act.

All the best to ever one

Almighty bless all of you

Warm regards and Best wishes

Dr. B.S Chandrashekar

President KN IADVL

HON. GENERAL SECRETARY SPEAKS

Congratulations to the energetic YUVADERMA team for bringing out another excellent issue of YUVADERMA E bulletin. This dynamic team is coming up regularly with novel ideas and also implementing these ideas efficiently. I thank the Chief editor Dr Preethi B Nayak and convener Dr Shwetha Bhadbhade for their contribution in bringing out this issue.

At CUTICON KN 2018, Mysuru we are introducing the Resident's session for the first time. This session will be planned and executed solely by the residents. Requesting all the residents to attend this session and make it a big success.

Strength of IADVL comes from its members. I request all of you to participate actively in all IADVL activities at various capacities. I also request you all to utilize the benefits offered by IADVL.

Long live IADVL

With warm regards

DR. MANJUNATHA R
Honorary secretary general,
IADVL Karnataka.

PAST ADVISOR SPEAKS

"Teamwork is at the heart of great achievement"

As the founding editor of Yuvaderma, I had the responsibility to bring to life this novelty envisioned by our then president Dr. Manjunath Shenoy and secretary general Dr. Shashikumar BM. I had the wonderful opportunity to draft the framework of this wonderful piece of literature and learning alike. We put together a team of talented and brilliant residents from all over Karnataka, only to grow as a family over the years to come. It was an honour to guide these young and promising individuals into achieving our dream of 'Yuvaderma'. With a team comprising of Dr. Shwetha Bhadbhade, Dr. Vaishnavi Gopal, Dr. Preethi B Nayak, Dr. Kirti Katwe, Dr. Dharam Kumar and Dr. Manoj Srinivasa, the first six Yuvaderms, our first issue was ready to see the light of day in May 2016.

The meaningful and beautiful cover page designed by Dr. Shashikiran A R, made its debut with the second issue in November 2016 reflecting the very essence of Yuvaderma of nurturing and moulding young minds into the building blocks of tomorrow. The fine layout, excellent quality and crisp finishing of the newsletter can be credited to the very talented Mr. Shridhar without whom our team would have been incomplete. A year and a half and three issues later, our team grew and expanded to welcome new talent and continues to grow with each passing year.

It makes me immensely happy to share that with IADVL-KN Yuvaderma as an example, the other states under the Resident Connect committee are now initiating their own Yuvaderma bulletins and groups to provide a platform to budding residents to come forward and showcase their academic and extra-curricular skills. With the sixth issue now moulding into its final form, yet another masterpiece is on its way for you to read and cherish. I

would like to thank everyone who has contributed to this journey of Yuvaderma for the last three years. My best wishes to the new incoming team and its captain, Dr. Preethi B Nayak, a diligent and hardworking dermatologist who I have had the opportunity to work with on numerous occasions.

Yuvaderma will always be very close to my heart as a sapling nurtured by us, now growing strong into a tree of knowledge, spreading its expanse all over the country and providing canopy to thousands of young and enthusiastic minds. May this tree continue to prosper for years and years to come by the residents and for the residents.

Best wishes,

Dr. Saloni Katoch,

Advisor, IADVL Resident Connect Committee 2018-19.

Founding Editor and Editor-In-Chief, Yuvaderma 2016-17.

Advisor, IADVL KN Yuvaderma 2017-18.

VANITY IS MY FAVOURITE SIN

In comparison to women, men visit a dermatologist less often and are less concerned about their cutaneous health in general. However, certain extrinsic factors make male skin more prone for damage. These mainly include smoking and exposure to UV radiations while other factors include pollution, repetitive muscle movements and diet. Smoking is more prevalent in males and is an independent factor for development of elastosis. Men being men generally avoid using sunscreens and are thus more prone to UV radiations in outdoor work leading to increased incidence of tanning and sunburns.

Beauty as a concept has been traditionally dominated by females world over. Even in various mythologies around the world, we find mention of several Goddesses epitomizing beauty- Aphrodite in Greek mythology or Venus in Roman mythology.

But quite fascinatingly, our Hindu Gods have been perpetually depicted with rouge on their cheeks in popular culture. Till recently, 'Male Aesthetics' which was long considered as a taboo, has now opened up a huge market for the cosmetic industry.

Today, progressive young urban men have become meticulous about their appearance. Lately, a new term "metrosexual" has been coined for such phenomenon. Sylvester Stallone (or Rocky to us) known for his rugged and chiseled appearance, is more than familiar with anti-wrinkle and facial aesthetic treatments. From treating his jawline and lifting his eyebrows to having regular Botox injections, Stallone is rumored to have it all done. This has made him stay relevant against the all odds. He is 72 now, need I say much?

There can be no denial that cosmetology has brought a new leash of life in a branch long considered to be 'dull' and 'monotonous'. Today, I can safely say that readers of this magazine are amongst the best minds of medical field.

With the staggering growth of Laser centers throughout the country, there has been an increasing trend to satisfy one's vanity by undergoing surgical as well as non-surgical cosmetic procedures (NSCPs). In India, men are showing increasing interest in NSCPs, more so than in surgical cosmetic interventions may be due to social stigma. [1]

Why is it important? : An admirable dressing and grooming sense do not only give a perception to others of how we feel about ourselves; but also gives a confidence boost to our self-image. The gist of the matter is, people feel good when they look good! Of course, beauty

lies in the eyes of the beholder; take this with a pinch of salt. [2]

How is Male Aesthetics different?

Biological Variations : Male skin is thicker and cutaneous appendages also show greater activity causing increase in sebum and sweat production. Hair distribution pattern is different due to the effect of androgens which converts small, straight, nonpigmented vellus hairs into coarse, pigmented, terminal hairs. Androgen-dependent areas include the chin, upper lip, chest, breasts, abdomen, back, and anterior thighs. [1,3]

Men have increased skeletal muscle mass including facial muscles. They also have a highly vascularized face due to the vascular plexus supporting the beard hairs which makes it more prone to bruising post treatment with injectables. [3]

Facial subcutaneous fat also varies among the two sexes. Men have lesser soft tissue area than women in the medial malar area of the cheek. This leads to a visibly flatter and more angular cheeks in men. [3]

Behavioral Patterns : In comparison to women, men visit a dermatologist less often and are less concerned about their cutaneous health in general. However, certain extrinsic factors make male skin more prone for damage. These mainly include smoking and exposure to UV radiations while other factors include pollution, repetitive muscle movements and diet. Smoking is more prevalent in males and is an independent factor for development of elastosis. Men being men generally avoid using sunscreens and are thus more prone to UV radiations in outdoor work leading to increased incidence of tanning and sunburns. [4]

Aging skin : Men have more severe facial rhytides or wrinkles except in the perioral area. The loss of subcutaneous adipose tissue with age along with thicker skin and more prominent facial musculature results in deeper expression lines in men as opposed to the superficial rhytides in women. This makes men appear older than their age when compared to women. [5]

Male Aesthetic Procedures

Botox Injections : Botox injections are undoubtedly the most common NSCP amongst men. Studies done in males undergoing botox injections in regards to dosing, safety and efficacy is limited. This becomes important in light of the facial anatomical variation between the two sexes. Overzealous attempt can lead to arching of the eyebrows or feminization of the face. [5]

Dermal Fillers : Dermal Fillers play a pivotal role in men seeking augmentation of their cheeks. However, injections are given laterally along zygomatic arch sparing the middle and anterior region.

Botox and Dermal Fillers should be approached with extreme caution. Careful study

of the anatomy should be done pre-procedure as scope for error is limited and any adverse effect on patient's face can cause repercussions on the doctor's face. [5]

Laser Beard Sculpting : Laser Beard Sculpting creates a natural beard line which makes men look younger with a stronger jawline. They can go without shaving for three or four days and not look scruffy. Each laser treatment lasts anywhere from a few minutes to an hour, and it usually requires at least six treatments four to six weeks apart to be effective. [5]

Laser Acne Scar Removal : Untreated or incorrectly treated acne causes pigmentation or scarring. Excessive scarring botches the facial contour. CO2 lasers have proven to be very effective in the treatment.

Care should be taken to counsel the male patients about post-procedure erythema and swelling and its management due to the attached stigma.

Chemical Peels : It is useful for treating acne vulgaris, acne scarring, rosacea, keratosis pilaris, melasma, actinic keratosis, photodamage, resurfacing of surgical reconstruction scars, and periorbital rejuvenation.

Male patients may require a greater number of treatments or higher concentration of peeling agent due to increased sebaceous quality of skin and hair follicle density. [5]

Conclusion : Men represent a small but fast-growing segment of the cosmetic industry. But they also tend to be more conservative and regardless of current trends, are less likely aware of gender specific procedures. Hence, they are an untapped pool for future cosmesis.

Dermatologists need to be aware of the gender wise anatomical and physiological difference as well as be sensitive to the behavioural and psychological variations. As future dermatologists we should redefine the concept of aesthetics to be more gender inclusive. Vanity is everyone's right to have.

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Dr Shivam Goyal,
PG-1, KMC, Manipal

PIONEERS IN DERMATOLOGY

HELEN OLLENDORFF CURTH – THE FIRST LADY OF DERMATOLOGY

Helen Ollendorff Curth was born in Breslau, Germany in 1899 to Jewish parents. She graduated from a medical school in 1923. Helen worked with Joseph Jadasshon in Breslau investigating the sensitivity of syphilitic skin lesions to a dull probe, which was later known as "Ollendorff probe" sign.

In 1924, she moved to Berlin where she worked under the mentorship of Abraham Buschke, a well-known dermatologist where she described a rare hereditary connective tissue disorder "Disseminated dermatofibrosis lenticularis" which was later termed as "Buschke – Ollendorff" syndrome. Helen was married to her fellow dermatologist Rudolf William Paul Curth in 1927. She formulated a criterion to diagnose paraneoplastic acanthosis nigricans which were popularly called as "Curth's postulates"

In 1954, together with fellow medical geneticist Madge Thurlow Macklin, she described a case series of Ichthyosis Hystrix which was later known as "Curth –Macklin ichthyosis". This was a rare genodermatoses and one of the syndromes named after two women.

In the later parts of her years, she was diagnosed with Alzheimer's dementia and died in 1982. She donated her brain for research purposes.

Dr. NAVYA,
PG-3,
Father Muller Medical College, Mangalore

RENDEZVOUS WITH THE MAN OF VISION : AN INSIGHT TO THE JOURNEY OF DR B S CHANDRASHEKAR, A LEADING DERMATOLOGIST AND AN ACADEMICIAN.

Dr B.S. Chandrashekar is the pioneer in the field of Aesthetics and Trichology. He is the Chief Dermatologist and Managing Director of Cutis Academy of Cutaneous Sciences, in Vijayanagar, Bangalore. He was the topper of Mysore University in the year 1995 and received Fellow of Diagnostic Excellence award by Glaxo India in 1997. He was the organising secretary of WCOCD 2017 held in Bangalore. He is currently the president of IADVL Karnataka and past IADVL SIG convenor for trichology.

Priyanka : Tell us something about your childhood. What made you pursue medicine? Why did you choose dermatology as your speciality?

Dr. B. S. Chandrashekar : Pursuing medicine was in the family. I was born as the fifth child with 2 sisters and 3 brothers, and because of my colour, my mother had told that I was destined to become a doctor, as soon as I was born. The intention of joining MBBS was there since high school, and I got a seat in Bangalore Medical College. During the course of MBBS you know everyone will develop passion for some subject, I developed passion for paediatrics. I tried for paediatrics for a long time. I wrote around 5 to 6 entrance exams with a ranking within 40 to 50 every time. Back then the demand for paediatrics was very high. I could put only 3 preferences - MD paediatric, DCh, MD General Medicine which I didn't get. The entire credit of me joining Dermatology goes to my friend Dr Manjunath, currently a professor of ENT at VIMS, Bellary. He was then a postgraduate in BMC and had seen that I was not taking any seat for almost 2 years. He collected my application form in which I had again put only 3 preferences. He added other preferences in which dermatology was the eighth choice out of twelve. Then I got M.D Dermatology in Mysore Medical College. So, I got into dermatology by chance. I joined in August but I started preparing for All India entrance exam that was going to be held in January with the intention of quitting dermatology if I had got a Paediatric seat. So, I had not studied dermatology in the initial few months. My then HOD, Dr Shivakumar, called me and asked me some basic questions like the primary lesions which I was not able to answer confidently. He then advised me for 30 to 40 minutes and it changed my attitude. Even my siblings advised me that if you want to do well you can do it in any field provided you develop a passion towards it and it all depends on you. Then onwards I started developing passion towards the subject and towards teaching. So, I started teaching my

juniors and final year students. I did extremely well in my post-graduation and went on to become the topper of Mysore university. I also wrote golden jubilee exam of Mysore University and topped that as well.

Pr : From a small clinic in 1997 to a full-fledged academic institute in 2018. Tell us about your journey. How did you conceive the idea of starting an academy with full-fledged fellowship courses.

Dr BSC : I was very popular in Mysore. Before I even wrote my final exams, I was recruited for the post of lecturer by Dr Jayadev, HOD of JSS Medical College. I also was very keen on finishing DNB before settling, as DNB was very difficult in those days and pass percentage was hardly 12%. So, I gave DNB and cleared in in one go. But my final calling was Bangalore and hence moved to Bangalore. I joined B.R. Ambedkar Medical College but left it because of the politics and soon started my private practice in 1997. I used to travel for nearly 85 km every day from BVK Iyengar road to Mathikere to Shobha hospital as a consultant almost until 2007. I started with small clinic of 360 sq. feet in BVK Iyengar road in a make-shift office that was run by my brother, a chemical engineer, as I did not have enough money to rent an office of my own. I belonged to a lower middle-class family and did not have much money, although we were very rich education wise and also my father was a high school teacher. My brother would run an office from 9 AM to 5 PM, and 5 PM onwards we would make it a clinic. There were hardly any patients for almost a year or so. I would see only 10 to 12 patients in a month for almost one year and that's when I finished Rooks textbook for the second time. It was a lean patch for at least 3 or 4 years. 2003 onwards I started seeing more patients up-to 80 per day. So, I decided to have an assistant and hired Dr Jagadish and we started running the clinic in the small place only. From then on there was no looking back. Making an academy was not my dream as I was only driven to see more patients every day and also by that time I was married and had a kid. So, I had other family responsibilities and priorities but I never compromised my passion for the subject. Even now I see any case as a fresh case like how we would see in post-graduation days. But in 2009 there was only one igniting factor. I went to a conference on leadership development in IIM Hyderabad conducted by Dr Reddy's and I was motivated by Dr Aravind of Aravind Eye Hospital in Chennai, Apollo chain of hospitals and other corporate hospitals. It shows how a single person can really bring changes and make an impact in the society by developing passion towards the subject. I was very much impressed by Dr Aravind's leadership in eye care facilities. They have around 110 centres around the globe and they have 2 divisions one for the well to do and one for the poor. Whatever revenue is generated by the well to do division flows back to the poor. Dr Aravind was a polio ridden doctor and became an ophthalmologist so that he can sit and operate and was never on TV or newspaper. The highest recognition he got was by WHO and that's when he came to limelight and built an empire. To become a leader is easy but to produce leaders is a great task. Aravind institute has produced hundreds of ophthalmologists including his own family members. I came back and spoke to my juniors Dr Raj Shekar, Dr Vani. By that time, we had shifted to a clinic of 2400 sq. feet in Chandra layout and were seeing 120 to 150 patients. So, we thought, why not start an academy. So, we got this plot of 7000 sq. feet and started constructing this place in 2011 and built five floors, and it was started in 2012. That was the fastest I have worked, as it was difficult to manage 200 patients in a small place. By

that time fellowships had started in Victoria hospital and Venkat Charmalaya and since we had all the required infrastructure I thought why not start an academy, and applied to the university for fellowship grant and got it by 2014. By that time Dr Madura joined us. She is the lead dermato-surgeon and heads the dermato-surgery department. Now this is one among the best centre for hair transplant. Dr Vani finished her fellowship in aesthetic from Cutis only and Dr Chaitra joined us. These three were the pillars. This is how it started.

Pr : You have big list of publications, clinical trials. How important is research and studies for a budding dermatologist? How do we strike a balance between both?

Dr BSC : If you ask me about that one setback of my career even today I feel it is publications. I was only concentrating on my clinical practice. Although we have enough clinical data we do not have the time to analyse it. Otherwise I would have published more than 500 articles given the amount of data and the clinical intuition I had. But then we started publications once the academy was started and other colleagues joined in. So, my message to young dermatologists is 2 things. One, have passion towards the subject. Clinical dermatology is the solid foundation based on which you can develop any speciality. All yesteryear dermatologists who have made a mark in the subject are good clinical dermatologists and then you have to develop your area of interest. This is lacking in the younger generation. Their clinical knowledge is very inferior to what we had. Second is research and publication. As a 1st year postgraduate only we have to develop the ability to look into a case in a different way. My professor used to say “every case of scabies has to be seen as a fresh case as every case could teach you something new.” If you have the intuition to read

between lines you can see an entire new world. In the same subject you can tease and get into the depth of the subject. It helps you in writing articles and secondly it will help patients too. Any contribution to the patient community is commendable. If you are dedicated like that people will follow you and you will be a leader right from the post graduate days. So, if you take any selection criteria for a speaker, 1st thing they look at is their publications, in your speciality of interest. That’s what I lacked for 12 to 13 years, of course now after starting the academy we are doing a lot of research

Pr : Last 2 decades has seen tremendous growth in medical technology. As we can see you have constantly been updating yourself with those and been implementing them in your day to day practice. How do u manage it? What would you advise the residents regarding the same?

Dr BSC : That's what yesteryear dermatologists lacked, institutes or fellowship programmes to teach us. I first learnt laser when Dr Rajendran started National skin centre. At that time, he invited me and I saw my first laser treatment. So, I developed passion for lasers. The entire knowledge has come through reading, attending workshops and conferences. There has been no formal training. One message is when you start your practice invest at least 40 % of your earnings in modernising the clinic and to procure equipment. Attend conferences and learn from your seniors, do it for free for few months till you understand the dynamics and once you are well equipped with it you can do it on a large scale. Start as a pilot and then go for mass production. Your career is 80% of your life, so invest in it. I am a voracious reader. Learn from colleagues, learn from books, conferences. U should at least carve out 1 to 1.5 hours of reading time to keep yourself updated about the latest technologies.

Pr : Tell us about your experience as the organising secretary of WCOCD 2017?

Dr BSC : When it comes to community or association activities godfather is Dr Sacchidanand. He was the one who inspired me. WCOCD was a challenge as it was the first time it was happening in India and Dr Venkataram was the initiating factor. The biggest challenge was funds and place to accommodate 4000 delegates as it was a global centre. The budget was around 15 crores. We decided to do it at the Bangalore agricultural university and I think my popularity in the industry helped garner sufficient funds and also my colleagues chipped in and entire scientific committee was taken care of by Dr Venkataram. My other colleagues and of course my team at cutis had my back at all times. There were some hitches may be due to lack of infrastructure but overall it was a success. 92% of people were satisfied with the conference in the survey we conducted.

Pr : What are your goals and vision as the current president of KN IADVL?

Dr BSC : There's no dearth of learning opportunities for clinical dermatology. There is a conference or workshop every 15 days or so. But a clinic is not solely run by a clinician, but also needs ancillary staff. But hardly do they get an opportunity to sit and learn in a conference. My main agenda was to have a programme for them and hence I rolled out "Saarathi". We conducted 20 to 25 programmes across Karnataka to teach the staff. They learn the technique of talking to patients, fixing appointments, keeping time etc. To keep up with the modern day treating practices it was very important. The second programme was "primary connect" starting on Sept 15th in Gulbarga next month. The main idea was to sensitise the primary care physicians, the basic treatment of common dermatological conditions and at what point they have to refer. It is impossible for 12000 dermatologists to cater for a population of 1.3 billion. Third programme was to strengthen existing post graduate training and strengthen journals and also having an own land for IADVL Karnataka.

Pr : What is your take on the commercialisation of dermatology clinics by investors (eg, Kaya / Olivia). How is it affecting the dermatologists as entrepreneurs? Is it a boon or a bane?

Dr BSC : One thing is it is commercialised and second being these practices are eroding ethics. You are hiring fresh pass-outs and asking them to apply peels on active acne to achieve a target of a particular number of procedures for incentives. This makes people lose faith in dermatology and go for alternative medical practices like Ayurveda and Homeopathy. This is a very important issue we discuss often. The way out here is, young

dermatologists with a solid clinical knowledge should be trained under a senior dermatologist for a year or two and then take 5 to 6 like-minded dermatologists specialising in different fields and start a centre which can be as good as Kaya. So, during your postgraduate days only you will have to connect with the like-minded people, now that it is very easy to socialise and connect because of social media like Whatsapp or Facebook. Secondly the government is giving loans at subsidised rates for doctors. Start your practice with small devices like radio frequency. In this competitive world you are getting good quality lasers for 35 lakhs. Invest small and once you make enough, buy the best quality instruments and that is how you groom yourself. I came from a lower middle-class background and if I could do it, then anybody can. Only thing is you should have passion and vision and dedication towards it.

Pr : What inspired the conception of Aasare? Tell us more about it.

Dr BSC : This was initiated when U.T. Khader was the health minister. We are looking forward to adopting one of the PHCs in the periphery and conducting skin camp weekly. And also start a clinic for poor people in Cutis itself probably starting from the beginning of 2019. We have taken from the society and now it is time to give back to the society. In-fact, we, at Cutis believe in making no noise. Cutis caters to at-least 5 old homes, 3 blind schools and education to the poor people. This is what I learnt from the conference in IIM – your work should speak for itself.

Pr : What do you feel are the neglected areas in dermatology and where do you see dermatological practices in future? What do you think is the next big thing in dermatology?

Dr BSC : Cosmetology and Dermatosurgery are booming now. But probably the chronic diseases

like psoriasis and eczema will have to be taken care of. The menace caused by tinea, HIV and steroid abuse will have to be curbed. Now we have moved from disease to wellness and more of a beautifying process. But it shouldn't be so as it is detrimental to the subject and at large the community.

I gave a talk on future dermatology in Mumbai. I was talking about improvisation of clinic, upgrading of gadgets and future will be technology driven. It may be imaginary but robotics may be the next big thing. May be one can sit in a remote centre and do a hair transplantation surgery on a patient with the help of robots. But one to one connectivity can never replace any technology as human emotions drive doctor patient relationship as we are all driven by emotions.

Pr : What do you think about the current scenario regarding the life of residents after post-graduation? Has dermatology reached a point of saturation? Is fellowship mandatory for survival? Teaching institute or corporate set up?

Dr BSC : Firstly, you should have a clear vision on what you want to be. If you want to do dermatosurgery join a fellowship and if you don't get one, join a senior practitioner who is practising dermatosurgery. After all, you won't have a certificate but you will still be eligible to practice

dermatosurgery legally. But tell in the beginning, how long you are going to stay to your senior so that they can have a plan. Stay at least for one and half to two years to gain sufficient experience. Don't have short term goals. Also, the practice in a medical college is entirely different from private practice. Our motto in Cutis is "seeing is not believing, reading is not believing but experience is believing." So, experience lasers, surgeries or aesthetics for that matter, and have respect for your seniors. This is something lacking in our youngsters.

Pr : Tell us about the most endearing and satisfying experience of your career

Dr BSC : Establishing Cutis Academy

Pr : You were the topper of Mysore university. What would you advise the residents to achieve academic excellence?

Dr BSC : The five pillars of success are passion, vision, hard work, dedication and sincerity.

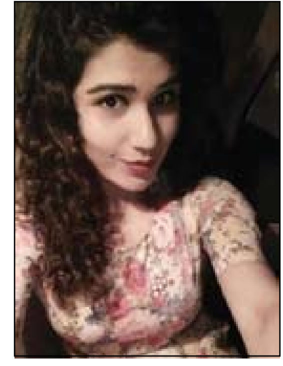
Rapid fire :

1. **One textbook that u feel you should have studied but didn't during your PG days.**
- Journals
2. **What does Aasare mean to you?**
- Helping poor people with passion.
3. **Books or e books?**
- Books
4. **Histopathology or dermoscopy?**
- Histopathology
5. **Favourite actor?**
- Rajkumar
6. **Sweets or savoury**
- My wife
7. **If not a doctor then which other profession?**
- Mechanical engineer
8. **That one thing you always wanted to buy but haven't yet**
- Nothing
9. **Favourite sport and sportsperson**
- Cricket, Sachin tendulkar
10. **Women who inspired you the most.**
- My sister
11. **Facebook / Whatsapp / Instagram. social media or social menace?**
- 80 : 20
12. **Mandatory rural service. Is it justified taking into consideration lack of facilities or good pay?**
- No, it is not justified.
13. **Favourite speciality. Cosmetology / trichology / dermatosurgery / pediatric dermatology / dermatopathology**
- Trichology
14. **One adventure sport you want to tick off your bucket list**
- Tennis
15. **Favourite exam questions**
- Follman's balanitis (the only question I didn't answer in my final MD exam)

As I left that place, I was only full of admiration for the dedication and passion towards subject that beamed through sir's eyes. I had taken back a lot more than what I had gone with. Those words of wisdom still echo in my head and gives us hope that one can achieve wonders if we have a vision, work sincerely and with dedication towards attaining it. Thank you Sir, for taking your time out and for those valuable pearls of wisdom.

Dr Priyanka Karagaiah,
PG - 2
BMCRI, Bangalore.

A MOOT BETWEEEN OLD SCHOOL 'V/S' NEW SCHOOL



Shilpitha Srinivas,
PG-3, Navodaya
Medical College, Raichur.

Shibani Bhatia,
PG-2,
KMC Manipal, Manipal

The argument of which is better : The use of Technology for teaching versus Textbook learning has been going on for ages. Every Professor or student has their own viewpoints on this. These are some of our view points on this topic.

Point 1 : Learning is more extensive in...

Shilpitha Srinivas : When we use technology, we can refer more books and compile everything into one presentation and thus learn more and teach others also in the process. We can discuss about rare cases which we may not come across normally and use pictures and videos to make others aware about how to manage such cases. Certain techniques like dermatosurgery techniques which may not be known in one's own hospital can be learnt through videos online.

Shibani : Case discussions focus on learning more than teaching others. Others also learn indirectly as anyone could be asked a question during case discussions and it also helps in applying what we have learnt.

Point 2 : Detailed exploration of a topic:

SS : When we use technology, we can refer more number of books and add videos and animation to the presentation which helps to make the lecture more interesting and people are engaged in what is happening during the lecture, it makes our understanding of the subject more picturesque and clear.

S : Detailed study about one particular topic is also possible with textbook learning and case discussion. We can get the opinions of Senior consultants and those who have a vast experience in handling such cases to give their opinion on the case. It helps in in-depth study of one topic and related topics also. Eg . during case discussion, we discuss the various possible D/D s and then discuss about them too. Textbook gives us certified knowledge, students can get misguided with general information through internet if not researched through a proper platform.

Point 3: Training versus reflective thinking:

SS : We get trained in Public speaking and develop effective communication skills. We also become well conversant with the use of computers and the use of technology. This will be helpful in research, publications and presentations in our future career. This will help to boost our confidence. Presentations also encourage the collaboration between colleagues and this helps us to develop a good rapport with our colleagues.

S : Case discussion and/or chalk board learning is useful as we can apply our knowledge into the discussion and helps us to simplify topics. This way we can retain information easily. Also, in power-point presentation, we cannot assess the feedback and the level of understanding of the audience. This is not a problem during case discussion as everyone

is asked questions during the discussion! Eg. We can make a simplified diagram of difficult mechanisms and this will help us to retain the information better.

Point 4 : Learning made interesting:

SS : Using technology learning is made more interesting. Using video calling applications like skype, we can even have online workshops and classes. It helps to enrich the curriculum with interdisciplinarity.

S : With the help of group discussions and debates we can compare various treatment modalities or procedures for various diseases. This makes learning fun and brings out the pros and cons of each treatment modality.

Point 5: Improves Communication Skills:

SS : The usage of appropriate technology and animations can help to convey the patient's condition, use of technology boosts our communication skills over all

S : Case presentation helps in improving our observation skills and also helps in improving our skills in communication with the patient. There is direct patient- doctor interaction. This will be useful as we are trained from PG life itself how to have good bedside manners.

Point 6: Access of Information:

SS : With the use of technology, even remote colleges, with less staff can access journals and articles from reputed hospitals and famous dermatologists. They can learn valuable skills from these pioneers in the field of dermatology with minimal cost with the touch of a button.

S : Case discussion gives more time to access information. Making power-point presentations takes more time. Also using a power-point requires a certain set of skills. Knowledge of how to use the power-point feature is needed to effectively create a power-point. Individuals with little computer experience may find it difficult to use.

Point 7 : Cost Saving:

SS : We can get updated information easily which may not be the case if we continue to use old editions of textbooks due to lack of financial resources. Often it takes 3- 4 years for a new edition of a textbook to be released. People who depend only on textbooks as their source of Information have to read old information until the new books get released.

S : By borrowing books from the library, we don't have to spend money on buying e books or purchasing the full text of Journals. For a power-point presentation a system is required, a projector screen and electricity will be required. The success of a presentation depends entirely on the proper functioning of technology. Sometimes due to technical difficulties, the presentation may not go as planned.

Point 8 : Reliability of Information:

SS: With the use of technology, we are subjected to the same information through different routes, through sight, hearing, and even 3D videos. Thus, information becomes more concrete and the reliability factor increases. This is useful for rare cases. It also helps to increase wonder about a condition.

S : Nothing can beat seeing a real case and patient. The memory of that lasts forever. In group discussion and case presentation, we have to purely display our knowledge. Whereas while making a ppt, we often get carried away due to feature abundance like animation, slide designs. The presenter might end up compromising on the facts, losing the actual focus.

Point 9 : High lighting of points :

SS : With the use of power-point presentations, tough topics can be concised and made into important points. This makes learning easier and faster. The power-point presentations are useful if one needs to rapidly revise more information within

a short period of time, like just before exams.

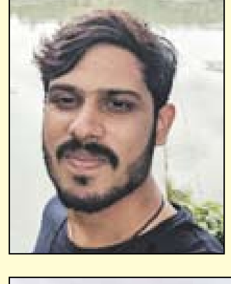
S : Electronic files may be lost as a result of computer errors or an accidental deletion. Often, we collect many Ppts but we don't have time to go through it. Whereas whatever we discuss, we are able to retain for a longer time period.

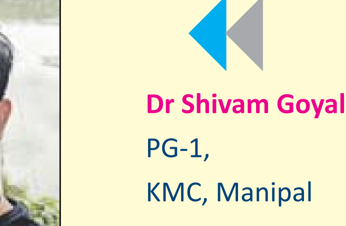
Point 10 : Engagement of Students :

SS : I feel that students are engaged to an extent with the use of technology. Even if the learning is made slightly more interesting with the use of power-point presentation, it makes students a bit lazy as notes are just handed out to them. There is no work on their part.

S : Numerous studies of College Students, show that students learn better when they are actively engaged. Discussions are probably the most powerful yet easiest way to get students actively involved. During power-point presentations, it often becomes a one-sided conversation and soon the audience loses interest and focus. The passive learning or copying of content from the internet may not give clear long-lasting understanding of the subject unlike textbooks which requires efforts to write, learn and then convey making the information solid.

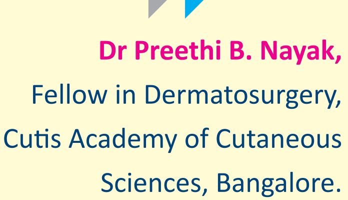
At the end of the day, learning has to be made productive and effective. Both have their own pros and cons. A balance of power-point presentations and discussions is the formula for a good teaching program, similar to what we already have in our curriculum.





Dr Shivam Goyal,
PG-1,
KMC, Manipal

Dr Preethi B. Nayak,
Fellow in Dermatosurgery,
Cutis Academy of Cutaneous
Sciences, Bangalore.



MY STINT WITH THE THEORY DERMATOLOGY EXAM...

Before I begin, I humbly thank the almighty, my family & friends and my teachers for believing in me at a time when I was racked with self-doubt. It was indeed one of the most significant moments of my life to receive the RGUHS gold medal from the Vice-President Shri. Venkaiah Naidu. It is indeed a pleasure and honour to share my experiences and a few deets and tricks I picked up during the course of my postgraduation years. Before we go into them, what I want to stress here is– every method described here cannot resonate with every student. Celebrate your individuality. Pick up the methods that resonate with you and modify the ones that you don't connect with. Recognise your strengths and work on your weaknesses. Below, I have attempted to assimilate my experiences, my mistakes and my triumphs to present a few methods you can adopt in the last few months of exam.

FEW MONTHS BEFORE THE THEORY EXAM

- First step is to decide the number of readings you want to complete before the final exam and fix up the duration needed for each reading. Ideally three to four readings are enough to give you confidence and two readings are a minimum requirement. Four months of dedicated preparation would be sufficient to achieve this.
- Approach the subject paper wise rather than finishing up the volumes. This gives you a better idea of your progress and the duration needed to finish preparing for a paper in further readings.
- Do not spend a lot of time on the so called "out of textbook" or "bouncer" questions. The crux of the matter is that every paper is bound to have a few tough questions and these questions are usually not repeated. Thus, it is advisable to search answers for these questions at the end of the day when your absorption power is at the minimum. You can also talk to your seniors and request them for their notes on such questions to save time.
- Choose a book as your core text book. There is no "best book". Choose a well- accepted and recognised book, whose language you can easily follow. The rule of thumb here is, each book and each author have their own strong and weak points and you will need to refer a few other books for few topics that are not well presented in your core book.
- Make notes, particularly for anatomy and physiology of skin, for the topics that are not well presented in your core text book and the ones that you have researched from various books. It is ideal that you start making your notes for second year onwards but writing notes for essential topics in few months before exam is also sufficient.
- Keep a book for diagrams and figures with you since the first reading. Divide this book into 3-4 sections depending on the number of the papers and start jotting down figures, diagrams, histopathology figures, schematic representations into the book. Keep going through this book whenever you are bored or at night before sleeping and also the night before the final exams. I cannot stress enough that figures and diagrams are a vital way to score

marks in your theory paper and sincerely thank my seniors and teachers who advised me regarding this book.

- The point of theory exams is not to check who has the most knowledge but rather who can assimilate one's vast knowledge and then present it to suit the question asked in such a way that the examiner can easily get a grip of what the student is trying to communicate. What I mean here is the onus of making your point in the paper lies on you and not the examiner. Hence, from your second reading onwards, approach any topic in the form of a question. For instance, if you are reading sebaceous glands; approach it as if it was a 10-marker question. Plan the answer in your mind. Make up different headings that pop out and think about various figures/tables/ schematic representations you can use in the answer. Jot this down in some corner of the notes. This will give you three advantages.

1. Because you have tried to create headings, organise diagrams and give a structure to a particular topic, it helps you to retain the information better.
2. Once you bring your own uniqueness to a topic, it makes the examiner's job easier to grade your answer, helping you score more when compared to the student who has written the same points as you but has not organised his/her answer.
3. Finally, because you have already structured the answer in your head, it will come easily to you in the examination hall and you will not have to spend vital moments thinking about how you want to answer a particular question.

Example, while reading Gunther's disease; you can plan your answer under following headings: Introduction, history, epidemiology, etio-pathogenesis, clinical features, diagnosis, complications, course and prognosis, treatment.

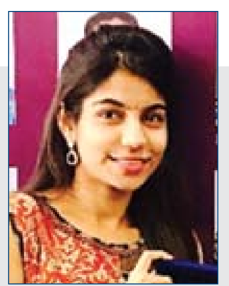
- When planning your answers, do not forget to use diagrams. If the textbook does not offer you a diagram for a particular topic, do not be afraid to create your own schematic representation for the condition. Please remember that the examiners understand the crunch of time you experience in exam and do not expect 'finished pieces of art' but rather expect legible, informative diagrams that convey all the information needed in a simplistic and appealing manner.
- Keep another book by you - the "forget-me-not book" - where you make several sections to suit your needs. My book had sections on syndromes, mnemonics, historical aspects, epidemiological aspects and so on. Tailor this book into sections you feel are hard for you to remember.
- Try to stick to your schedule but also know that delays by a few days are not the exception but rather the rule. Hence, give yourself a few buffer days between each reading. You will repeatedly feel that you are unable to recall anything you read. This is completely normal. Do not panic. Everything that you have read comes back to you in the examination hall.

IN THE EXAMINATION HALL

- Read the paper 2-3 times and make sure you understand all the questions.
- Start with the questions you are most confident in answering and proceed onwards.
- Give more time to the first three questions (even though all questions now carry same marks) because these first few questions are where you can impress your evaluator.
- Write legibly, focus on the headings, diagrams and tables rather than presenting the evaluator with sagas. Remember, it is not the information you put across but rather the way you put across the information that will give you the edge.
- Stay calm and collected and do not panic if there are a couple of difficult questions.
- I cannot stress enough about the advantages of legible handwriting and diagrams; need not be pretty- just legible.
- You will not be able to revise the whole subject in the 1.5 days between the papers. Do not fret over it, read the topics that you are weak in and glance through your strong topics. Here, the "book of diagrams" and "forget-me-not" book is of great help.

This journey - these last few months before the exams... It is going to be tough; but the view at the other side is worth it. Success is no accident. It is hard work, perseverance, learning, studying, sacrifice and most of all, love of what you are doing. I wish you all the very best in life.

Dr Sneha Gandhi,
Gold medalist (RGUHS-2017),
Senior resident,
GIMS, Gulbarga, Karnataka.



THE SKINNY TOON

Dr Gnana Prabha M,
PG-1,
KVGMCH, Sullia

BERRIES IN DERMATOLOGY

1. **Strawberry skull**

   Refers to the shape of skull on an antenatal ultrasound, seen in Edward's syndrome (Trisomy 18).

2. **Strawberry appearance in dermoscopy**

   It is seen as background erythema and red pseudo-network associated with prominent follicular openings, surrounded by white halo. Seen in Actinic keratosis and Lentigo maligna.

3. **Strawberry gums**

   Hyperplastic gingival lesions seen in Wegener's granulomatosis and Sarcoidosis.

4. **Strawberry nevus/ Strawberry hemangioma**

   It is a type of capillary hemangioma which appears as raised, red lumpy areas over the body.

5. **Strawberry tongue**

   It is an enanthem seen over dorsum of tongue characterized by inflammation and hypertrophy of fungiform papillae.

Causes :

a. Scarlet fever
b. Group A Streptococcal pharyngitis
c. Toxic shock syndrome
d. Yellow fever
e. Kawasaki disease

6. **Strawberry cervix (Colpitis macularis)**

   It is characterized by punctate macular haemorrhages in cervix secondary to Trichomonas vaginalis infection.

7. **Mulberry molars**

   These are multiple rudimentary enamel cusps on the permanent first molars seen in Congenital syphilis.

8. **Mulberry like erosions**

   Granulomatous ulcers seen in Paracoccidiomycosis.

9. **Blueberry Muffin lesions**

   It is a descriptive term used when an infant is born with multiple blue/purple papules or nodules in the skin secondary to extramedullary haematopoiesis.

Causes :

a. TORCH infections
b. Coxsackie B2 infection
c. Parvovirus B19
d. Congenital syphilis
e. Rh incompatibility

10. **Black berry stomatitis**

    Seen in Paracoccidiomycosis

11. **Raspberry tumour**

    An umbilical adenoma seen in patent vitello-intestinal duct.

12. **Raspberry-like appearance**

    Framboesia (Yaws), a non-venereal spirochaetal infection affecting children caused by Treponema pertunae is characterized by raspberry like excrescences.

13. **Bunch of grapes appearance**

    Seen in Botryomycosis.

14. **Cherry angioma (Campbell de morgan spots)**

    These are benign tumours due to abnormal proliferation of blood vessels, characterized by cherry red papules on the skin.

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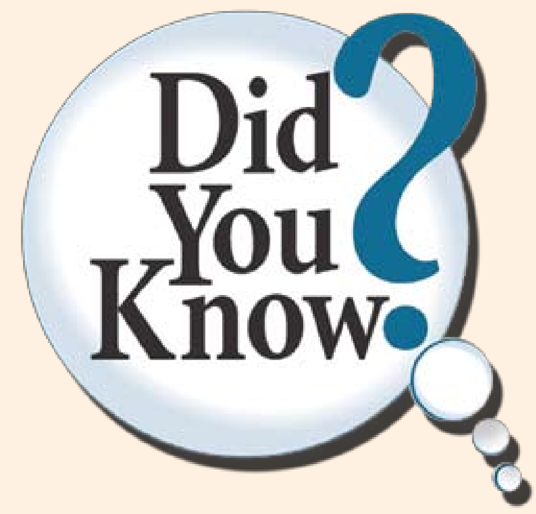
Dr. NAVYA,
PG-3,
Father Muller Medical College, Mangalore



- Believe it or not, humans have the same number of hair follicles per square inch as a Chimpanzee!
- Healthy hair can be stretched up-to 30% of its length when wet
- Your skin can release up-to 3 gallons of sweat in hot weather!
- Average adult's skin spans 21 sq, feet, weighs 9 lbs & contains more than 11miles of blood vessels & 45 miles of nerves
- In a lifetime, a human being will grow around 6 feet of nose hair
- Our eyes are body's only internal tissue directly exposed to UV light. 94% of people do not know exposure to UV light can damage their eyes
- A single strand of hair can support up-to 6.5 pounds of weight. That means a whole head of hair can support up-to 2 tons!

Dr Ambika C R,
PG-2, MIMS,
Mandya

KEEP CALM AND UNSCRAMBLE!

Unscramble these 10 jumbles to form words describing lines and named bodies in dermatology

LINES IN DERMATOLOGY

DRHENRIE __ __ __ __ __ __ __ __

ASTAPI __ __ ○ __ __ __ ○

HOCLKBAS __ ○ __ __ __ __ __ __ __

RENRFGIITNP ○ __ __ __ __ __ __ __ __ __ __

KHEMCREU ○ __ ○ __ __ __ __ __

NAMED BODIES IN DERMATOLOGY

NEPXTARI __ __ __ __ __ __ __ __

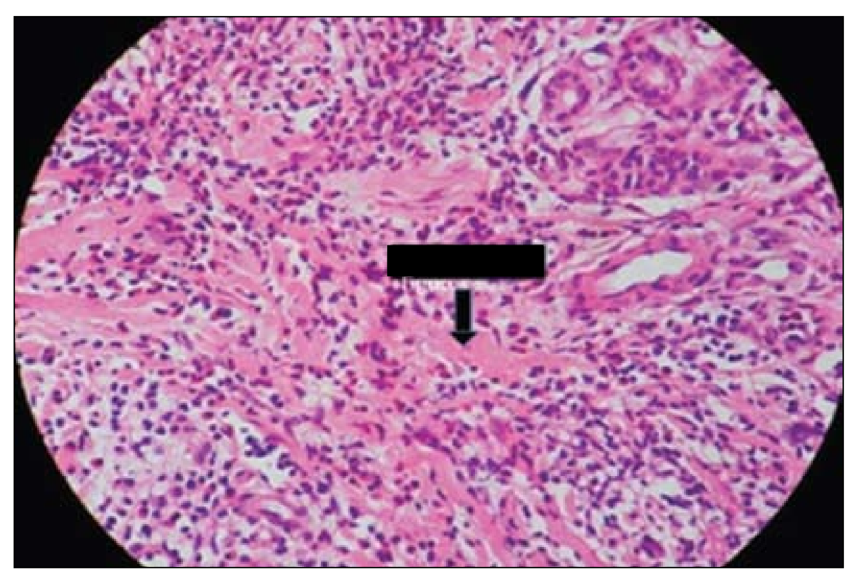
NRAIGEIUR ○ ○ __ __ __ __ __ ○ __

MIFRMOUR __ __ __ __ __ __ ○ __ __

ARSODABU __ __ __ __ __ __ __ ○

NOARIPKARE __ __ __ __ __ __ __ __ __ ○

Now arrange the circled letters to form the surprise answer as suggested by the image given below.



Answer : __ __ __ __ __ __ __ __ __ __ __ __

Dr. Gagana Gopal,

PG 2, MIMS,

Mandya.

CASE REPORTS

DERMOSCOPY OF HYPERTROPHIC LICHEN PLANUS : SECRETS REVEALED BY THE EXPERT - Dr. Balachandra S. Ankad

A 20 year-old-male presented with asymptomatic plaque on the right index finger since 2 years. Examination showed purplish plaque with slight rough surface (Figure 1). Dermascopy and skin biopsy was done. Dermoscopy was done using hand held DermLite with 10x magnification which revealed pearly white areas, comedo-like openings, perilesional brown pigmentation, and yellow areas on bluish background (Figure2). Histopathology demonstrated features suggestive of hypertrophic lichen planus (HLP). Pearly white areas, comedo-like openings, brown pigmentation, yellow areas and bluish background correspond to Wickham striae, follicular plugging, epidermal melanin, basal layer degeneration and dermal melanin respectively. Clinically lesion appeared similar to chromoblastomycosis and lupus vulgaris. However, dermoscopy showed characteristic patterns of HLP which was reinforced by histopathology. Thus dermoscopy is a non-invasive diagnostic tool that assists in the accurate diagnosis of inflammatory condition such as HLP.

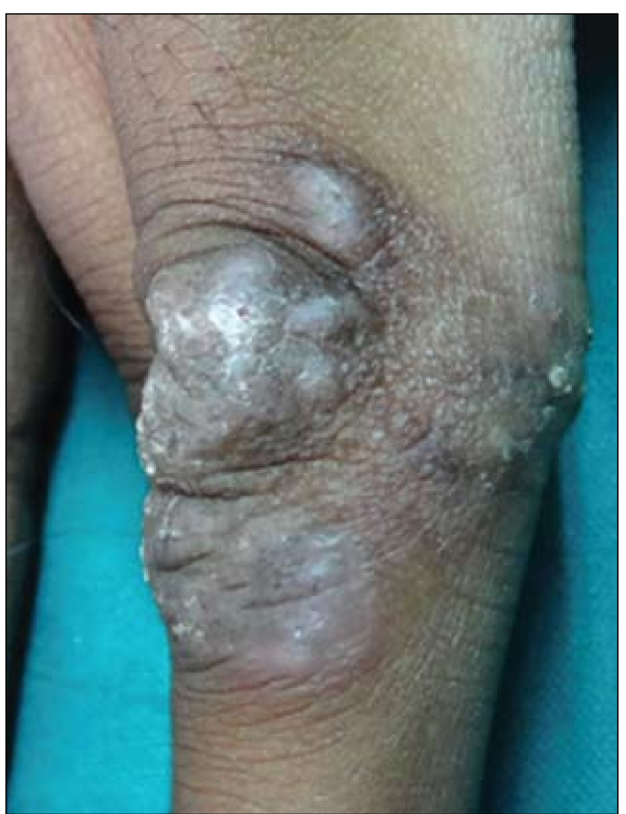


Figure 1 : Clinical image of hypertrophic lichen planus showing well defined bluish plaque on the index finger.

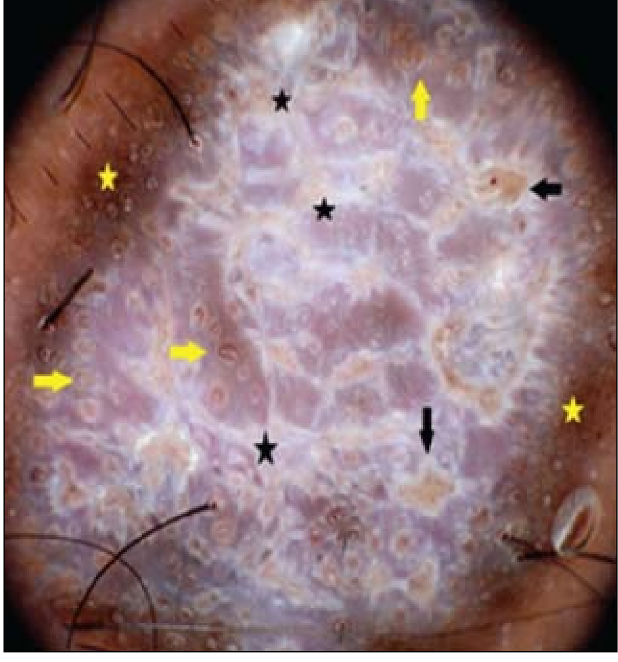
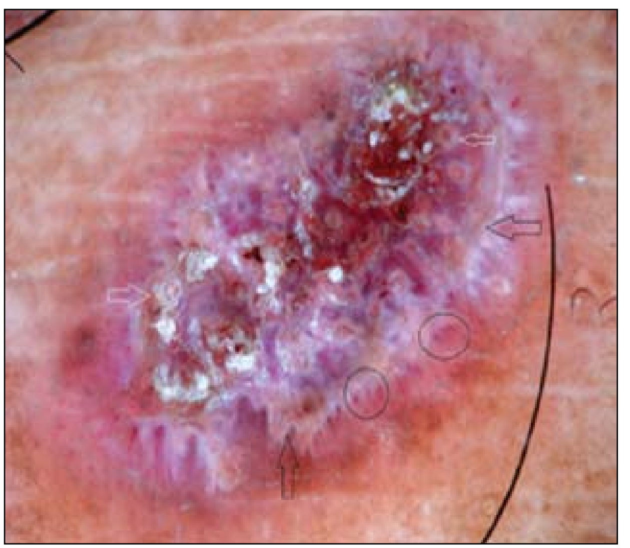


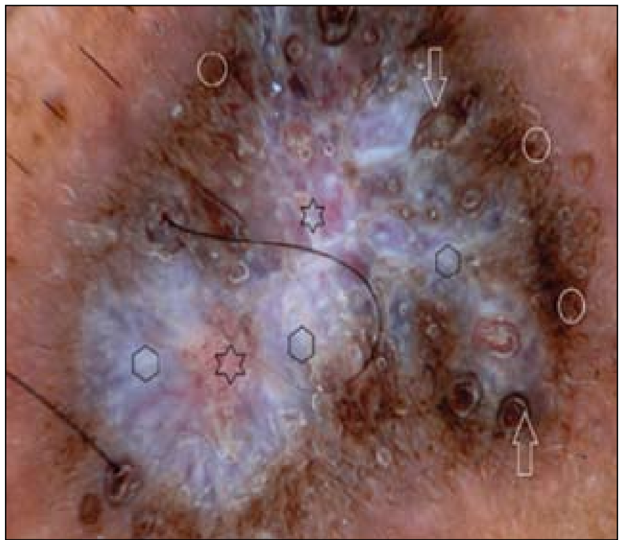
Figure 2 : Dermoscopy of hypertrophic lichen planus: pearly white areas (black stars), comedo-like openings (yellow arrows), yellow areas (black arrows) and perilesional brown pigmentation (yellow stars). Note that characteristic bluish background is well appreciated.

Hypertrophic lichen planus (HLP) is the second most common cutaneous variant of lichen planus. It is characterized as extremely pruritic, and thick hyperkeratotic plaques, which are seen primarily on the shins or dorsal aspect of the foot and may be covered by a fine adherent scale. The lesions are usu¬ally symmetrical and tend to be chronic because of repetitive scratching. Later, lesions become hyperkeratotic thickened elevated purplish or reddish plaques and nodules.[1]

Histopathology of HLP reveals epidermal hyperplasia, acanthosis, hyper - granulosis and compact and lamellated hyperkeratosis centered on follicular infundibula and acrosyringia. Basal cell damage is usually confined to the tips of rete ridges and may be missed on casual observation [2]. Band - like infiltration is distinctly missing in the dermis [3]. These pitfalls in histopathology of HLP make it difficult to diagnose histopathologically, unlike classical LP. Collagen bundles are oriented vertically in the papillary dermis in association with an increased number of eosinophils[2].



Dermoscopy of hypertrophic lichen planus shows yellowish structure (black arrows), comedo-like openings (white arrows) and peripheral blood vessels (circles).



Dermoscopy of hypertrophic lichen planus shows gray-blue globules (hexagons), comedo-like openings (arrows), brownish-black dots(circles) and red globules (stars)

Proposed dermoscopic patterns corresponding to histopathologic features in hypertrophic lichen planus [1].

	Dermoscopic patterns	Corresponding histopathologic changes
1	Pearly white areas (Wickham striae); and peripheral striations	Compact orthokeratosis above zones of wedge-shaped hypergranulosis, acanthosis, and dermal fibrosis
2	Gray-blue globules	Dermal melanophages
3	Comedo-like openings	Hypergranulosis and hyperkeratosis of dilated infundibulum
4	Red dots	Dermal capillaries
5	Red globules	Dermal capillaries
6	Brownish-black globules	Epidermal melanocytes
7	Yellow structures	Spongiosis and vacuolar degeneration of basal cell.

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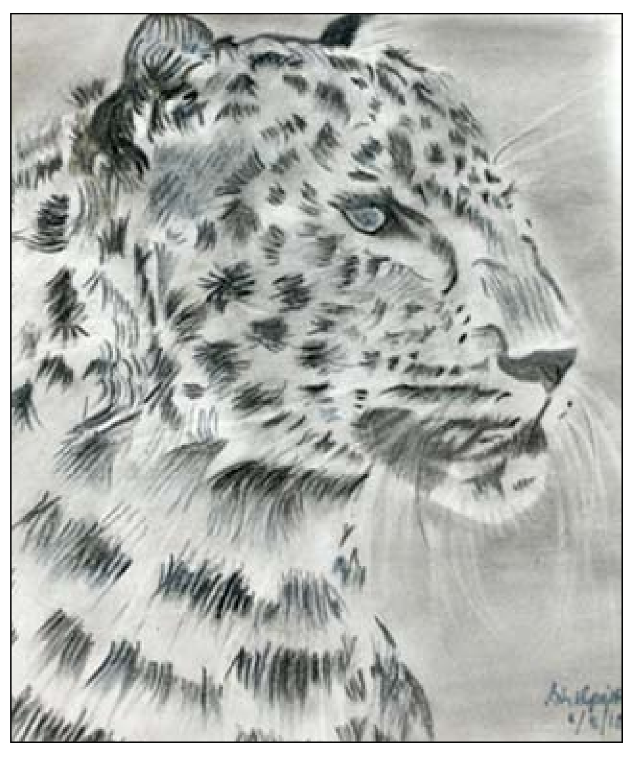
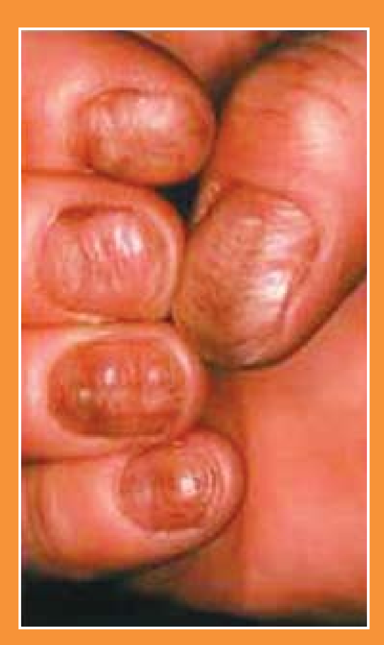


MEDIAN CANALIFORM DYSTROPHY OF HELLER – A RARE CASE REPORT



INTRODUCTION :

Median canaliform dystrophy of Heller also known as solenonychia, dystrophia unguis mediana canaliformis, and nevus striatus unguis in which longitudinal splitting occurs.[1] It is named after Heller who recorded first known case of the disorder in 1928. The majority of cases of median canaliform dystrophy are idiopathic. Other causes includes. traumatic injury to the base of nails, use of oral retinoids, subungual skin tumours such as glomus, myxoid and other tumours resulting in longitudinal grooving and lifting of nail plate from the bed.[2] Sweeney et al reported a familial clustering of cases of median nail dystrophy.[1,3] We describe a case of idiopathic median canaliform dystrophy of Heller.

CASE REPORT :

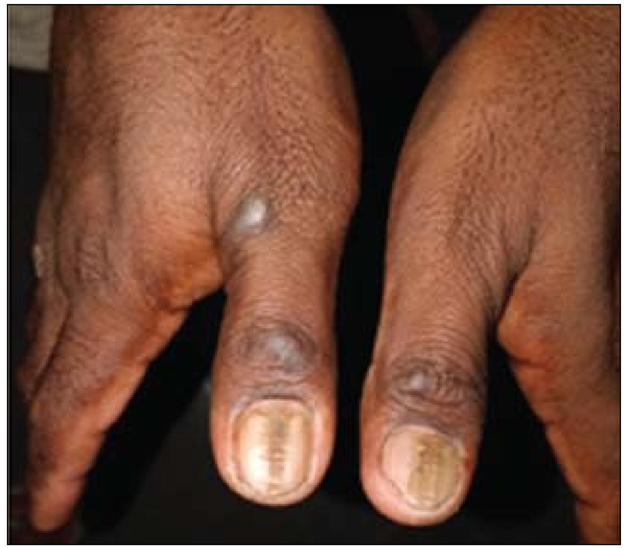
A 45year old male patient presented with discoloured nails with irregularities over thumb and index finger since 2 years. There was no history of use of oral retinoids or other medications, contact with irritants or allergens. He denied any nail disorders or psychiatric disorder in family. Examination revealed a single median longitudinal groove with transverse furrows arising from median split over both thumb nail, index finger. Other nails were normal. No skin lesions present elsewhere. Systemic examination was unremarkable. Diagnosis of median canaliform dystrophy was made on clinical basis.

DISCUSSION :

MCD also known as solenonychia or dystrophia unguis mediana canaliformis or nevus striatus unguis presents with small cracks or fissures that extend laterally from central canal or split toward the nail edge giving the appearance of an inverted fir tree or Christmas tree. The condition is usually symmetrical and most often affects the thumb, although other fingers or toes may be involved. Thickening of the proximal nail fold, enlargement and redness of lunula may occur. Habitual tic deformity, digital mucous cyst, lichen striatus, nail patella syndrome, pterygium, Raynaud's disease are other conditions in which longitudinal nail defect have been described.[4] Treatment is many times challenging for a dermatologist as no therapy has shown to be consistently successful. Injecting triamcinolone acetonide into dystrophic nail is one option. Recently reported treatment is the topical application of 0.1% tacrolimus once daily without occlusion. Topical tazarotene 0.05% ointment known to normalize the process of keratinisation has been used by Madke et al.[5]

CONCLUSION :

To summarize median canaliform dystrophy of Heller belongs to a heterogenous group of rare nail conditions with far from satisfactory line of management. We report this case for its rarity.



Longitudinal grooves in a fir-tree pattern on b/l thumb

Transverse furrows on the index finger

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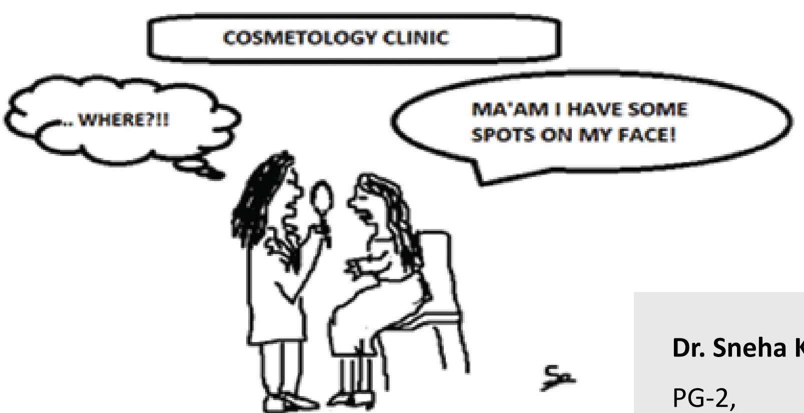
THE SKINNY TOON



EVER EXPERIENCED THIS?!

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SPOTTERS

PYOGENIC GRANULOMA : DISCUSSION WITH THE EXPERT - Dr. Umashankar Nagaraju

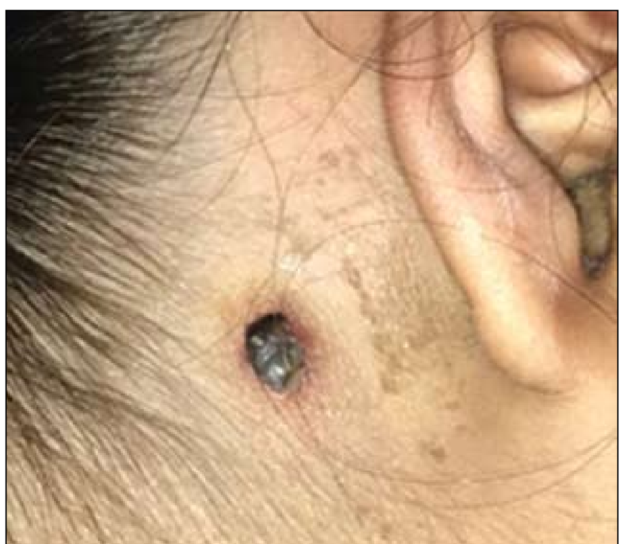


Fig 1 : Pyogenic granuloma

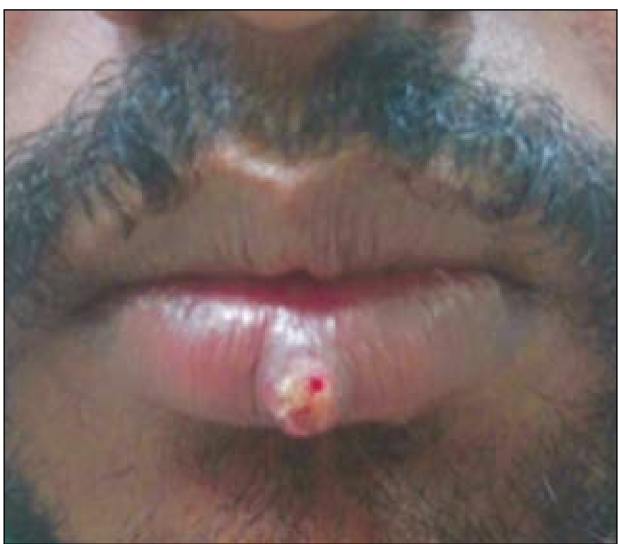


Fig 2 : PG of lip

What is a pyogenic granuloma?

A benign vascular tumor that develops rapidly, often at the site of a recent injury, composed of a lobular proliferation of capillaries in a loose stroma.[1]

Can you name some synonyms for this condition?

- Lobular capillary hemangioma.
- Granuloma telangiectaticum
- Cocker and Hartzell's disease
- Granuloma pyogenicum
- Granuloma pediculatum benignum
- Epulis telangectium granulomatosa
- Granuloma gravidarum (in pregnancy)

Which organism causes pyogenic granuloma?

- Pyogenic granuloma (PG) is not caused by any organism. It a misnomer as it neither contains pus nor does it represent a granuloma histologically.

What is the etio-pathogenesis of this condition?

- PG is a type of inflammatory hyperplasia as a response to a minor injury or any underlying irritation. In a minority of cases, a minor injury, usually of a penetrating kind, has occurred a few weeks before the nodule appears. Lesions may also occur at the sites of burns. There may be no history of trauma, but an underlying irritating factor such as calculus, poor oral hygiene, non-specific infections etc.
- Cases have been reported of eruptive pyogenic granuloma following lightning injury.2
- Rare variants like subcutaneous PG have also been seen in association with anti-phospholipid antibody syndrome.
- The underlying fibrovascular connective tissue becomes hyperplastic along with proliferation of granulation tissue.
- Factors like inducible nitric oxide, vascular endothelial growth factor, or connective tissue growth factor are involved.

Name a few drugs which can result in PG-like lesions?

- Gefitinib
- Systemic 5-fluorouracil
- Capecitabine
- Topical and systemic retinoids

How would a case of pyogenic granuloma typically present?

- PG may be seen in any age, most commonly in children and young adults.
- It affects both sexes with a predilection for males except for lesions that occur in the oral cavity which are more common in females.
- The common sites are the hands, especially the fingers, the feet, lips, head and upper trunk, and the mucosal surfaces of the mouth and perianal area.
- Inspection reveals a solitary, bright red or brownish red to blue-black in colour, papule or nodule, often with a subtle collarette of scale.3 The surface of early, bright-red lesions is usually thin, intact epidermis. Older and darker lesions are frequently eroded and crusted. Occasionally, the surface is raspberry-like or verrucous. The size varies between 5 and 10 mm, but may reach 50 mm. The outline is rounded. The base is often pedunculated and surrounded by a collar of acanthotic epidermis; the lesion may also be sessile. On palpation: It is partially compressible, but cannot be completely blanched and non-pulsatile. It is non-tender and bleeds on touch.

Name some rare variants of PG.

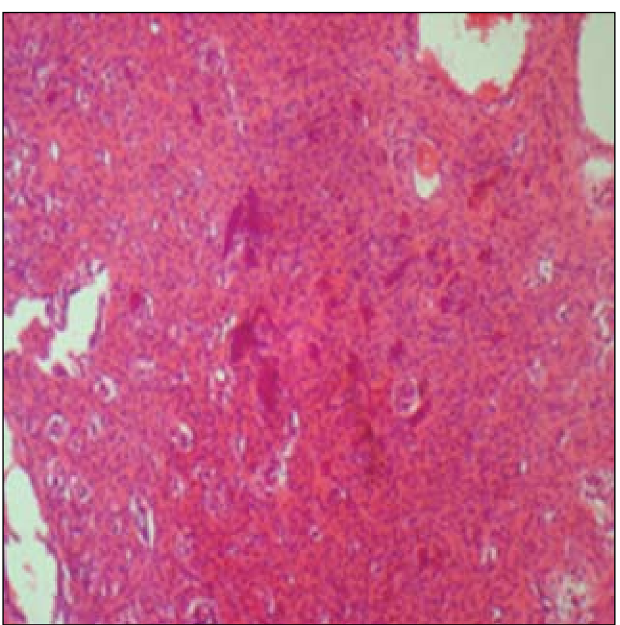
- Subcutaneous
- Intravascular
- Eruptive (multiple, with satellite lesions)
- Granuloma gravidarum is a variant of pyogenic granuloma that presents in the oral cavity during pregnancy.

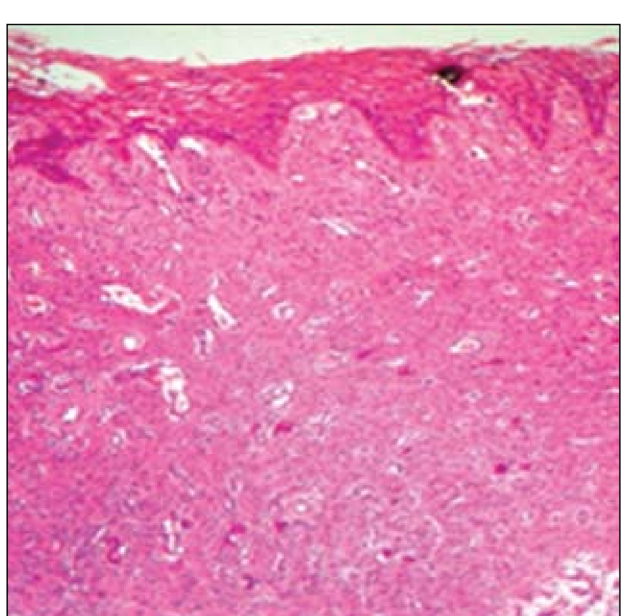
What is Warner- Wilson- Jones syndrome?

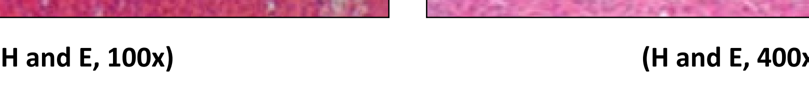
- It is a rare, benign condition characterized by recurrent pyogenic granuloma with multiple satellite lesions.4

Describe the histological features of a lesion of PG.

- There is a lobular proliferation of small blood vessels, which erupt through a breach in the epidermis to produce a globular pedunculated tumour.
- The epidermis forms a collarette at the base of the lesion and covers part, or all, of the tumour in a thin layer.







(H and E, 100x) (H and E, 400x)

Fig 3 & 4- Histopathological picture of Pyogenic granuloma showing numerous vascular channels of varying calibre associated with intense inflammatory infiltrates.5

- The proliferating vessels are set in a myxoid stroma, lacking in collagen in the earlier stages and relatively rich in mucin.
- The endothelial cells are plump, as in new granulation tissue, lining the vessels in a single layer.
- They are surrounded by a mixed cell population of fibroblasts, mast cells, lymphocytes, plasma cells and, where the surface is eroded, polymorphonuclear leukocytes.
- Mitotic figures may be prominent.
- Older lesions tend to organize and partly fibrosed and may show focal bone formation. There can also be focal degenerative atypia, raising the possibility of malignancy.

Name some differential diagnoses for pyogenic granuloma.

- Keratoacanthoma- Seen mostly on sun-exposed skin of the face, forearms, and dorsal aspects of the hands. It is typically represented by a solitary lesion growing rapidly within a few weeks, and subsequently showing a slow involution over a period of a few months.
- Bacillary angiomatosis (eruptive PG) - It shows an almost identical histology to that of pyogenic granuloma. However, in bacillary angiomatosis, pale epithelioid endothelial cells are prominent, neutrophils and nuclear dust are seen throughout the lesion and violaceous amorphous aggregates of bacilli which are positive with either Giemsa or Warthin–Starry stains are easily identified. The causative organism Bartonella henselae or B. quinatana may also be identified by PCR.
- Viral warts- Hyperkeratotic or veruccous sessile or pedunculated lesions with tenderness on lateral pressure more than perpendicular pressure.
- Molluscum contagiosum - Dome shaped skin coloured umbilicated lesions are typically seen.
- Glomus tumour - Painful tumor arising from glomus body, found under the nail, on the fingertips or feet.
- Eccrine poroma - Tumor derived from acrosyringium of apocrine glands; <1-2cm erythematous, shiny exophytic lesions mainly seen on palms and soles. Histologically the cells are PAS positive and surrounded by normal keratinocytes.
- Inflamed seborrhoeic keratoses- The lesion looks like a brownish black hyperkeratotic papule/ nodule/plaque with a pasted-on appearance and surrounded by erythema.
- Kaposi's sarcoma - Tumors usually start as bluish-red macules on the distal portions of the lower extremities, progressing slowly into firm plaques and nodules. A rare variant such as PG-like Kaposi's sarcoma can be difficult to be differentiated clinically. The tumor surroundings frequently show a pitting edema, which may evolve into fibrosis. HPE shows enlarged endothelial cells of capillaries protruding into the lumen of fascicles of spindle shaped cells.

How would you treat a case of pyogenic granuloma?

- Pedunculated lesions are easy to treat by curettage with cauterization or diathermy coagulation of the base. It is desirable to excise a narrow, but deep, ellipse of skin beneath the lesion and close the wound with sutures.
- Topical imiquimod 5% cream has been found to be successful both in children and adults with complete resolution.
- Other treatment modalities that have been used include Nd:YAG laser, cryosurgery, intralesional steroids, flash lamp pulsed dye laser and even injection of absolute ethanol.

What is the reason behind recurrence of PG post-excision/ cautery?

- A considerable proportion of pyogenic granulomas recur after such treatment, because the proliferating vessels in the base extend in a

conical manner into the deeper dermis.

- In rare instances, particularly in children, and sometimes following treatment, satellite lesions which have a similar pathology to the primary lesion may develop around a pyogenic granuloma.

Describe the natural course of pyogenic granuloma?

- The initial evolution is rapid, but growth ceases after a few weeks. Spontaneous disappearance is rare.

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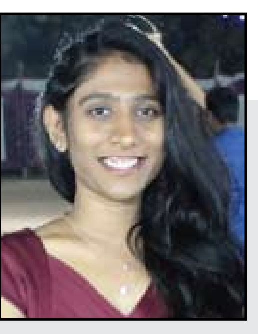


THE BALLOT BOX

1. What is the most distressing thing about being a medical resident?

a. Huge curriculum and long learning curve 44%

b. Being underpaid 16%

c. Assault and other medicolegal stuff 10%

d. Restricted leisure-time 14%

e. Matter of life and death 0

f. Bullied by seniors/ staff 6%

2. Why did you take up dermatology?

a. Comfortable working hours 56%

b. Passion for subject 30%

c. Glamour and attention 0

d. Because I got a good score in NEET 0

e. Suggested by family/friends/seniors 16%

3. The most challenging aspect of being a dermatologist –

a. Meeting patients' expectations 74%

b. Defending your branch from fellow residents/family members 6%

c. Daily OPDs 14%

d. Limited job opportunities 6%

4. Dermatological condition you tussle to diagnose in OPD?

a. Tinea pedis/mannum 42%

b. Soft corn 14%

c. Atopic dermatitis 14%

d. Allergic contact dermatitis 22%

e. Pityriasis alba 0

5. If given a choice, you would pursue this branch for your fellowship -

a. Dermatopathology 8%

b. Dermatosurgery 38%

c. Pediatric dermatology 18%

d. Trichology 8%

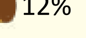
e. Cosmetology 28%

6. When in doubt, the first thing you do –

a. Riffle through the textbook immediately 6%

b. online browsing 28%

c. Discuss with colleagues/seniors 52%

d. Approach staff directly  12%

7. If you had to pick a teaching program, you would choose?

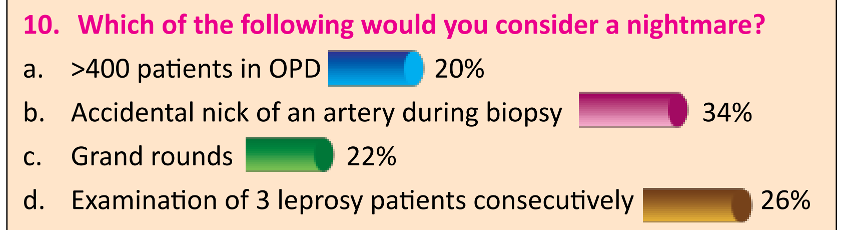
a. Seminar 10%
b. Case presentation 38%
c. Journal club 12%
d. Quiz 10%
e. I prefer being audience! 30%

8. Your idea of stressbuster –

a. Binge eat 10%
b. Movie/ series marathon 24%
c. Dress up & Party! 12%
d. Music/ dubsmash 14%
e. Sound sleep 38%
f. Shop shop shop 8%

9. During a seminar, I would most likely be doing this –

a. Pay attention and scribble notes 58%
b. Doze off 14%
c. Wandering thoughts 26%
d. Glued to my cellphone 0
e. Restless leg shaking 2%

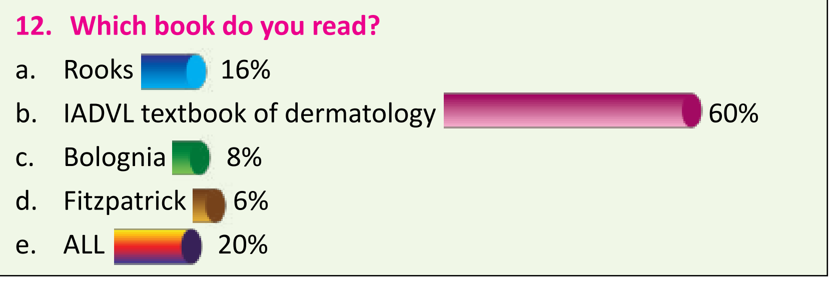


10. Which of the following would you consider a nightmare?

a. >400 patients in OPD 20%
b. Accidental nick of an artery during biopsy 34%
c. Grand rounds 22%
d. Examination of 3 leprosy patients consecutively 26%

11. If not dermatology, which other field would you have taken up?

a. Radiology 32%
b. Medicine 24%
c. Surgery 4%
d. ONLY AND ONLY DERMATOLOGY 38%



12. Which book do you read?

a. Rooks 16%
b. IADVL textbook of dermatology 60%
c. Bolognia 8%
d. Fitzpatrick 6%
e. ALL 20%

13. On a Saturday night, where would you rather be?

a. Dancing at a club 10%
b. At the Movies 8%
c. Good Restaurant 40%
d. Sleeping 40%
e. At home/library reading 6%

14. Which is your favourite procedure in Dermatology?

a. Chemical peels 14%
b. Laser 32%
c. Electrosurgery 24%
d. Skin biopsy 30%

15. How do you react when other department pgs get shocked to see you at the emergency room?

a. Act all cool and just ignore 40%
b. Be like, jealous much? 12%
c. Get angry and be like what do you think? 0
d. Get defensive and tell them how we get serious cases too. 42%

16. Which is your favourite social media platform?

a. Facebook 14
b. Whatsapp 54%
c. Twitter 2%
d. All 18%
e. I'd rather be antisocial 10%

17. Which part of our speciality you find most difficult?

a. Dermatolopathology 40%
b. Genodermatoses 26%
c. Venereology 14%
d. Connective tissue disorders 4%
e. Basics in dermatology 14%

18. Which is your favourite topic in dermatology?

a. Vesicullobullous disorders 32%
b. Pediatric dermatology 8%
c. Papulosquamous disorders 26%
d. Pigmentary disorders 26%
e. Connective tissue disorders 12%

Concept by : Dr Preethi B. Nayak
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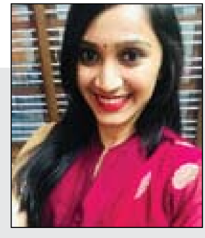

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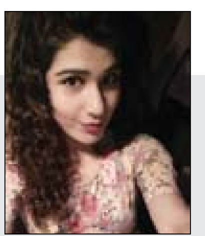

Namma IADVL- KN

DERMATOLOGY TERMINO - GENESIS

No other speciality of medicine has as much burden of descriptive morphology as does dermatology. Every conceivable change in the skin, no matter how trivial, has to be described and distinguished from normal. Here is a small effort to make the life easier for dermatologists, in which the literal meanings of certain dermatological terms are compiled.

- ACNE, akma/acme(plural) : peak, highest point(Latin & Greek)
- AINHUM, to saw or cut (eyun, ayun: saw)
- ALBINISM, ALBA, albus: white (Latin)
- ANETODERMA, anet : slack
- APOCRINE, apo + krinein : to separate(Greek)
- ARCIFORM, arc: in curves, form: shaped (Latin)
- ATOPY, atopia : out of place/ placelessness (Greek)
- ATROPHY, a : without, trophe: nourishment, fed
- BERLOQUE DERMATITIS, berlock(German), berloque (French): trinket, charm, pendant
- BIOPSY, bio: life, opsia: to view
- BOTRYOMYCOSIS, botryo, botrys: bunch of grapes(Greek), myces: fungus
- BULLA : blister, bubble (Latin)
- CAFÉ-AU-LAIT : coffee with milk
- CARBUNCLE : charcoal (Latin)
- CANCER : crab
- CHANCRE: little ulcer(Latin)
- CHICKEN POX : chickpea
- COMEDO : comedere : to eat up/ glutton(Latin)
- CUTANEOUS LARVA MIGRANS: creeping eruptions
- CUTIS : skin(Latin)
- CYTOLOGY : kytos: hollow vessel/container (Greek)
- D'EMBLEE : at once/ then and there (French)
- DERMATOSIS, derma: skin, osis: a state
- ECOLOGY, oikos: household, logos: management (Greek)
- ECTHYMA, ekthyma : breaking out (Greek)
- ECZEMA, to boil or flow out (Greek)
- EMOLLIENT, emollire : to soften (Latin)
- EPHELIS, EPHELIDES : sunspot, rough spot (Greek)
- ERUPT, erumpere : break out/ burst forth
- ERYTHRODERMA, erythro: red, derma: skin
- EXANTHEMATOUS, exanthema : breaking out, anthos : blossom of flower (Greek)
- FAVUS : a honeycomb(Latin)
- FURUNCLE : petty thief (Latin)
- GUTTATE, gutta: drops
- HERPES, herpein: to creep (Greek), serpere: to crawl (Latin)
- HELIX, helissein: to twist or roll
- HELMINTH, helmins: a worm
- HIDRO, hidros: sweat(Greek), ANHIDROSIS: absence of sweating
- HIRSUTE, hirsutus : hairy, to bristle i.e to make one's hair stand on end
- HORMONE, horme: impulse(Greek)
- HOSPITAL, hospitalia : apartments for stranger or guests(Latin)
- HYGIENE, hygieia: health(Greek)
- HYPHAE, hyphe: web
- IATROGENIC, iatro+gennan: to bring forth/ as a product of Iatros: healer, genesis: origin
- ICTERUS, ikteros : jaundice or yellow bird
- ICTHYOSIS, icthys : fish
- ID, ides: son or daughter
- IDIOPATHIC, idio: that which is personal, private or one's own/ peculiar, pathos: disease
- IMPETIGO, impetere: to attack (Latin)
- IMMUNE, im: not, mun: serving
- INCIDENCE, incidere : to happen, occur or befall
- INCISE, incidere : to carve or cut into
- INCOGNITO, incognitus : unknown (Latin)
- INCUBATE, incubare: to lie in or to brood
- INDEX : a sign or mark of something
- INDOLENT, indolentia : freedom from pain
- INDURATION, indurare : to harden
- INFECTION, inficere: to dye or stain / to corrupt or spoil

- INFESTATION, infestare : to annoy
- INFILTRATE, infiltrer: to soak in
- INFLAMMATION, inflammare: to set of fire, to kindle
- INFUNDIBULUM : funnel
- INFUSION, infundere : to pour into
- INGUINAL, inguen : the groin
- INJECT, injicere : to throw into
- IN SITU: in the original position or place
- INTERTRIGO, interterere, inter: between, terere: to rub
- KERATIN, kera: horn
- KERION, honeycomb/ wax(Greek)
- KOILONYCHIA, koilos: hollow or concave, onyx: nail
- KWASHIORKAR: red boy/ displaced or strange child
- LEPROSY, lepros: scaly, rough or mangy
- LEUKONYCHIA, leuko: white, nychia: nail (Greek)
- LICHEN PLANUS, leichen: tree moss(Greek), planus: flat (Latin)
- LIVIDO, lividus: network
- LUPUS: a wolf(Latin)
- LYMPH, lympha: clear water
- MACRO, macros: long, in space or time
- MEASLES, miscellus or miscella : miserable (Latin)
- MNEMONIC, mneme : memory
- MOLLUSCUM, mollis: soft or spongy (Latin)
- MORPHEA, morph: of or in a form
- MORPHOLOGY, morphe: form, shape oe appearance, logos: a discourse
- MYCOSIS, osis: any condition, myc: that is fungus infection
- NECROBIOSIS, necro, nekros: deadbody/ death, biosis: way of life(Greek) ; replacement of dead material by living elements.
- NEOPLASM, neo: new, plasm: growth
- NEVUS, naevus: birthmark(Latin)
- ONYCHIA, a condition of nail
- ONYCHOCRYPTOSIS, onyx: nail, kryptos: hidden (Greek)
- ONYCHOMYCOSIS, onyx: nail, mykes:fungus (Greek)
- PAIN, peine / poena: a penalty or punishment
- PANNICULUS, pannus: a piece of cloth(Latin)
- PAPULE, papula: a pimple
- PEMPHIGUS, pemphix : blister/ bubble
- PHAEOHYPHOMYCOSIS: condition of dark hyphal fungus
- PHRYNODERMA: toad skin
- PIEDRA : stone (Spanish)
- PITYRIASIS, pityrion: bran, fine scale
- PLICA POLONICA: polish plait
- PORE, poros: passage, a way (Greek)
- PRURITUS, prurire : to itch (Latin)
- PSORIASIS, psora: to itch
- PYODERMA, pyo: purulent, derma: skin
- ROSACEA, rosaceus: rose colored (Latin)
- ROSEA : rose red
- RUBELLA : little red (Latin)
- RUPIOID, rupia/ rhupos : a dirt or filth(Greek)
- SARCOID, sark/ sarc: flesh, resembling flesh(Greek)
- SCABIES, scabere: to scratch(Latin)
- SCLERODERMA, sklerosis: hardness, derma: skin
- SECRETIN, secretus: that which is secreted (Latin)
- SHAGREEN, chagrin: rough skin
- SHINGLES, cingulum: girdle (Latin)
- SYCOSIS, sykosis: fig like (Greek)
- TINEA : larva
- TRICHOTILLOMANIA, tricho: hair, tillein: to pull or pluck, mania: to be mad
- URTICARIA, urtica: nuttle, urere: to burn (Latin)
- VITILIGO, vitelius: vale i.e pale pink flesh of calf (Latin) vitium: blemish
- VULGARIS: common
- XANTHOMA, xanthos: yellow, oma: swelling (Greek)
- XEROSIS, xer: dry, osis: pathological condition
- YAWS, yaya: sore
- ZOSTER: girdle

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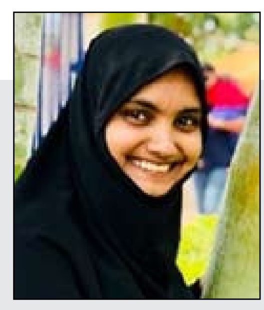


ಕನ್ನಡ ವಿಭಾಗ

ಕತ್ತಲೆಯಿಂದ ಬೆಳಕಿನೆಡೆಗೆ ಸವಿತಾಳ ಪಯಣ, ಬಿಳುಪು ರೋಗದೊಂದಿಗೆ

ಅಂದು ಸವಿತಾಳ ಮಗಳ ಮದುವೆಯ ದಿನ, ಎಲ್ಲೆಲ್ಲೂ ಸಡಗರ ಸಂಭ್ರಮ. ಮದುವೆಯ ಸಪ್ತಪದಿ ನಡೆಯುತ್ತಿತ್ತು. ಅಷ್ಟರಲ್ಲಿ ಹುಡುಗನ ಕಡೆಯ ಸಂಬಧಿಕರಲೊಬ್ಬರು ಹುಡುಗನ ತಾಯಿಯನ್ನು ಕೇಳಿದರು.

ಸಂಬಂಧಿಕರು : ಅಯ್ಯೋ ನೀವು ಈ ಮದುವೆಗೆ ಹೇಗೆ ಒಪ್ಪಿದಿರಿ? ಹುಡುಗಿಯಲ್ಲಿ ಯಾವ ದೋಷವು ಇಲ್ಲ ನಿಜ, ಆದರೆ ಹುಡುಗಿಯ ತಾಯಿಯನ್ನು ನೋಡಿದ್ದೀರಿ ಅಲ್ಲವೆ? ಅವಳಿಗಿರುವುದು ಅವಳ ಮಗಳಿಗೂ ಬಂದರೆ?

ವರನ ತಾಯಿ : ಏನು ಹೇಳುತ್ತಿದಿರಾ ನೀವು?

ಸಂಬಂಧಿಕರು : ಹುಡುಗಿಯ ತಾಯಿಗೆ ತೊನ್ನು ಅಂದರೆ ಬಿಳುಪು ರೋಗವಿದೆ.

ವರನ ತಾಯಿ : ಗೊತ್ತು ನಮಗೆ ಅದರಿಂದೇನು ತೊಂದರೆ?

ಸಂಬಂಧಿಕರು : ಅಯ್ಯೋ ಆ ರೋಗ ಅವಳಿಗೂ ಬರುತ್ತದೆ.

ಅಷ್ಟರಲ್ಲಿ ವರ ಮಧ್ಯ ಪ್ರವೇಶಿಸಿ ಹೇಳಿದನು.

ವರ : ಇದು ಯಾರಿಗೆ ಬೇಕಾದರೂ ಬರಬಹುದು, ನನಗೂ ಬರಬಹುದು, ನಿಮಗೂ ಬರಬಹುದು. ಇದೇನು ಅನುವಂಶಿಕ ಖಾಯಿಲೆ ಅಲ್ಲ. ಇವಳ ಅಮ್ಮನಿಗೆ ಇದ್ದ ಮಾತ್ರಕ್ಕೆ ಇವಳಿಗೆ ಈ ಖಾಯಿಲೆ ಬರಬೇಕಂತೇನಿಲ್ಲ.

ಸಂಬಂಧಿಕರು : ಒಂದು ವೇಳೆ ಬಂದರೆ?

ವರನ ತಂದೆ : ಇದೊಂದು ಚರ್ಮದ ಬಣ್ಣದ ಖಾಯಿಲೆ ಅಷ್ಟೆ ಜೀವ ಘಾತಕವೇನಲ್ಲ. ಅದಕ್ಕೆ ಬಹಳ ಪರಿಣಾಮಕಾರಿಯಾದ ಔಷಧಗಳು ಲಭ್ಯವಿವೆ. ಈ ರೋಗದಿಂದ ಬೇರೆ ಯಾವುದೇ ಹಾನಿಯು ಇಲ್ಲ.

ಸಂಬಂಧಿಕರು : ಈ ರೋಗ ಯಾವುದೋ ಪೂರ್ವ ಜನ್ಮದ ಪಾಪದಿಂದ ಬಂದಿರಬೇಕು ಅಥವಾ ಸರ್ಪದೋಷವು ಇನ್ನಾವುದೋ ದೈವ ದೋಷವೋ ಇರಬಹದು.

ವರನ ತಾಯಿ : ಇವರು ಈಗಷ್ಟೇ ಹೇಳಿದಂತೆ ಇದೊಂದು ಚರ್ಮದ ಖಾಯಿಲೆ. ಯಾವುದೋ ಪಾಪ ಅಥವಾ ದೋಷ ಅಲ್ಲ.

ಸಂಬಂಧಿಕರು : ನನ್ನನ್ನು ಕ್ಷಮಿಸಿ. ನನಗೆ ಈ ರೋಗದ ಬಗ್ಗೆ ತುಂಬ ತಪ್ಪು ಕಲ್ಪನೆಗಳಿದ್ದವು.

ಸವಿತಾ : ನಿಮ್ಮಂತೆಯೇ ತುಂಬ ಮಂದಿ ಈ ರೋಗದ ಬಗ್ಗೆ ತಪ್ಪು ತಿಳಿದುಕೊಂಡಿದ್ದಾರೆ. ನಾನು ಚಿಕ್ಕವಳಿದಾಗಿನಿಂದಲೂ ನನಗೆ ಈ ತೊನ್ನು ರೋಗವಿದೆ. ನಮ್ಮ ಮನೆಯಲ್ಲಿ ಇದು ಔಷಧಿಗಳಿಂದ ವಾಸಿಯಾಗದ ಖಾಯಿಲೆಯೆಂಬ ತಪ್ಪು ತಿಳುವಳಿಕೆಯಿಂದ ನನಗೆ ಯಾವುದೆ ರೀತಿಯ ಚಿಕಿತ್ಸೆ ಕೊಡಿಸಲಿಲ್ಲ. ಬದಲಾಗಿ ನನ್ನನ್ನು ದೇವಸ್ಥಾನಗಳಿಗೆ, ದರ್ಗಾಗಳಿಗೆ, ಸಾಧು ಸಂತರ ಬಳಿಗೆ ಕರೆದೊಯ್ದಿದ್ದರು. ಹಲವು ಪೂಜೆ ಪುನಸ್ಕಾರಗಳು, ಉಪವಾಸ ಹರಕೆ, ಜಪ, ತಪಗಳನ್ನು ಮಾಡಿಸಿದರು. ನನಗೆ ಕಲಿಯಲು ತುಂಬ ಆಸಕ್ತಿ ಇತ್ತು. ಆದರೆ ಶಾಲೆಯಲ್ಲಿ ಯಾರೊಬ್ಬರೂ ನನ್ನ ಜೊತೆ ಬೆರೆಯುತ್ತಿರಲಿಲ್ಲ ತಪ್ಪಿಯೂ ನನ್ನನ್ನು ಸ್ಪರ್ಶಿಸುತ್ತಿರಲಿಲ್ಲ. ಇದರಿಂದ ನನ್ನ ವಿದ್ಯಾಭ್ಯಾಸವು ಅರ್ಧದಲ್ಲಿಯೇ ನಿಂತಿತ್ತು. ಬಸ್ಸು ರೈಲ್ವೆ ಎಲ್ಲದರಲ್ಲಿಯೂ ಇದೊಂದು ಸಾಂಕ್ರಾಮಿಕ ರೋಗವೆನ್ನುವಂತೆ ನೋಡಿದರು. ನನ್ನ ಮದುವೆಯಾಗಲು ಬಂದ ಎಷ್ಟೋಂದು ಮಂದಿ ನನ್ನನು ಇದರಿಂದಾಗಿಯೇ ತಿರಸ್ಕರಿಸಿದರು. ನನ್ನ ಮಗಳ ಮದುವೆಯೂ ಹಲವು ಬಾರಿ ನನ್ನ ಈ ರೋಗದಿದಾಗಿಯೇ ಮುರಿದು ಬಿತ್ತು. ಇದರಿಂದಾಗಿ ನಾನು ಮಾನಸಿಕವಾಗಿ ಕುಗ್ಗಿ ಹೋಗಿದೆ. ಆದರೆ ಇಂದು ಇವರೆಲ್ಲರೂ ನಿಮಗೆ ಈ ರೋಗದ ಬಗ್ಗೆ ತಿಳಿಸಿ ಹೇಳಿದ್ದನ್ನು ಕೇಳಿ ಬಹಳ ಸಂತೋಷವಾಯಿತು. ಈ ರೀತಿ ಉಳಿದವರೂ ಕೂಡ ಈ ತೊನ್ನು ರೋಗದ ಬಗ್ಗೆ ಮಿಥ್ಯೆಗಳನ್ನು ತೊಡೆದುಹಾಕಿ ನಮ್ಮನ್ನು ಸಮಾಜದಲ್ಲಿ ಇತರರಿಗೆ ಸಮಾನವಾಗಿ ಪರಿಗಣಿಸಿದರೆ ಈ ರೋಗ ಪೀಡಿತರೆಲ್ಲರೂ ನೆಮ್ಮದಿಯ ಜೀವನವನ್ನು ನಡೆಸಬಹುದು.

ಡಾ. ಸಂತೋಷಿ ಎಂ. ನಾಯಕ್ ಎಂ.ಬಿ.ಬಿ.ಎಸ್., ಎಂ.ಡಿ,
ಚರ್ಮರೋಗ ಶಾಸ್ತ್ರಜ್ಞರು,
ಜ್ಯೋತಿ ಕ್ಲಿನಿಕ್, ಕುಮುಟ, ಉತ್ತರ ಕನ್ನಡ.

ತೊನ್ನು- ಕಳಂಕವಲ್ಲ?, ಕೇವಲ ವರ್ಣ ವ್ಯತ್ಯಾಸ...

ತೊನ್ನು ಎಂಬುದು ಮನುಷ್ಯರಿಗೆ ತಿಳಿದಿರುವ ಹಳೆಯ ರೋಗಗಳಲ್ಲಿ ಒಂದು. ತೊನ್ನು ರೋಗಕ್ಕೆ ಸುಮಾರು 3000 ವರ್ಷದ ಇತಿಹಾಸ ಇದೆ. ವೇದಗಳಲ್ಲಿ, ಈಜಿಪ್ಶಿಯನ್ ಬರಹಗಳಲ್ಲಿ ಇದರ ಬಗ್ಗೆ ಉಲ್ಲೇಖವಿರುವುದನ್ನು ನಾವು ಗಮನಿಸಬಹುದು.

ತೊನ್ನು ಅಂದರೆ ಆಂಗ್ಲ ಭಾಷೆಯಲ್ಲಿ VITILIGO ಎನ್ನುತ್ತಾರೆ. ಈ ಪದವು LATIN ಪದ VITIUMಎಂಬ ಪದದಿಂದ ಬಂದಿದೆಯೆನ್ನಲಾಗಿದೆ. CELSUS ಎನ್ನುವ ವ್ಯಕ್ತಿಯು ಮೊದಲ ಬಾರಿಗೆ VITILIGO ಎಂಬ ಪದವನ್ನು ಬಳಕೆ ಮಾಡಿದ ಎನ್ನಲಾಗಿದೆ.

ಚರಕ ಸಂಹಿತೆಯಲ್ಲಿ "SUITRI" (ಶ್ವಿತ್ರ) ಎಂಬ ರೋಗದ ಬಗ್ಗೆ ಹೇಳಲಾಗಿದೆ ಎಂದು ದಾಖಲ ಇದೆ. ಇದರ ಇತಿಹಾಸದಂತೆ ಅದಕ್ಕೆ ಅಂಟಿಕೊಂಡಿರುವ ಕಳಂಕಕ್ಕೂ ಕೂಡಾ ಇತಿಹಾಸವಿದೆ.

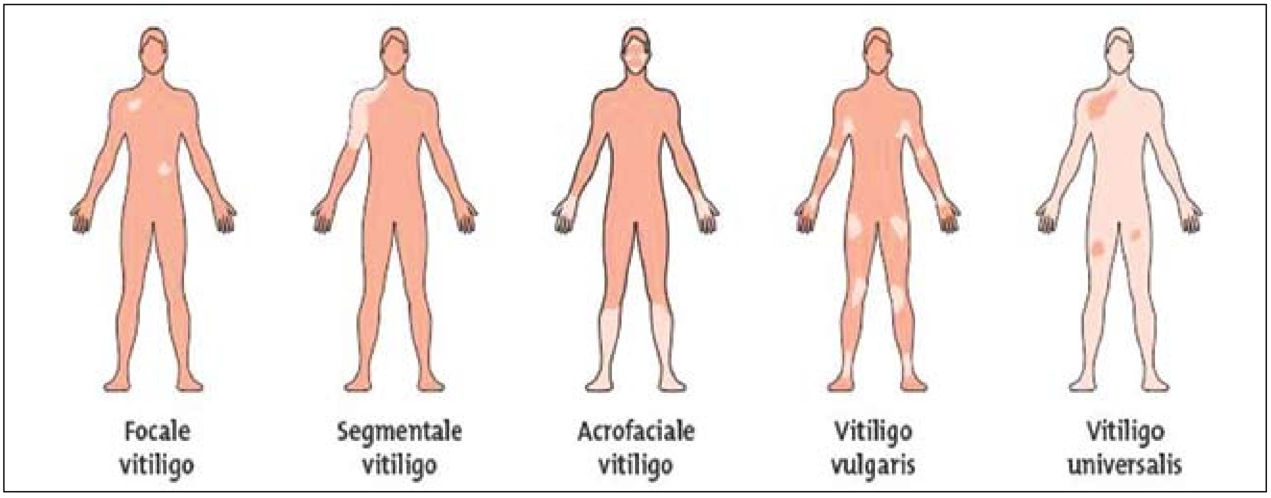
ಇದರ ಬಗೆಗಿನ ತಪ್ಪು ಕಲ್ಪನೆಗಳನ್ನು ನಿವಾರಿಸಲು ಇಂದಿಗೂ ಸಾಧ್ಯವಾಗುತ್ತಿಲ್ಲ. ವೈದ್ಯಕೀಯ ಕ್ಷೇತ್ರದಲ್ಲಿ ಇಷ್ಟೆಲ್ಲ ವೈಜ್ಞಾನಿಕವಾಗಿ ಮುಂದುವರಿದರೂ, ತೊನ್ನು ಕಾಯಿಲೆಯ ಬಗ್ಗೆ ಇರುವ ತಪ್ಪು ಕಲ್ಪನೆಗಳನ್ನು ನಿವಾರಿಸಲು ವಿಫಲವಾಗಿದೆ.

ತೊನ್ನು ವೈಜ್ಞಾನಿಕ ಸಮಸ್ಯೆಗಿಂತ ಹೆಚ್ಚಾಗಿ ಸಾಮಾಜಿಕ ಸಮಸ್ಯೆ ಎಂಬ ಅರಿವು ಮೂಡಿದರೆ ಅದರ ನಿವಾರಣೆ ಸಾಧ್ಯ.

ಶ್ವೇತ, ಶುಭ್ರ, ಎಂಬ ಇಬ್ಬರು ಹುಡುಗಿಯರು ಇದ್ದರು. ಇಬ್ಬರು ತುಂಬಾ ಬುದ್ಧಿವಂತ ಹುಡಿಗಿಯರು. ಕಾಲೇಜಿನಲ್ಲಿ ಒಳ್ಳೆಯ ಅಂಕ ಪಡೆಯುತ್ತಿದ್ದರು. ಆಟ, ಸಾಂಸ್ಕೃತಿಕ ಹಾಗೂ ಸಾಮಾಜಿಕ ಕಾರ್ಯಕ್ರಮದಲ್ಲಿ ಕೂಡಾ ಭಾಗವಹಿಸುತ್ತಿದ್ದರು. ಹೀಗೆ ಇರುವಾಗ ಇಬ್ಬರ ದೇಹದಲ್ಲಿ ಬಿಳಿ ಮಚ್ಚೆ ಕಾಣಿಸಿಕೊಳ್ಳಲು ಶುರುವಾಯಿತು. ಇದನ್ನು ಗಮನಿಸಿದ ಶ್ವೇತ ತಂದೆ – ತಾಯಿಯರು ಅವಳನ್ನು ವೈದ್ಯರ ಬಳಿ ಕರೆದುಕೊಂಡು ಹೋದರು. ವೈದ್ಯರು ಅದನ್ನು ತೊನ್ನು ರೋಗ ಎಂದು ನಿರ್ಣಯಿಸಿ ರೋಗದ ಬಗ್ಗೆ ವಿವರಿಸಿದರು. ಇದನ್ನು ಕೇಳಿದ ಶ್ವೇತಾಳ ತಂದೆ – ತಾಯಿಯರು ಆತಂಕಕ್ಕೆ ಒಳಗಾಗಲಿಲ್ಲ. ಶ್ವೇತಳಲ್ಲೂ ಧೈರ್ಯ ತುಂಬಿದರು. ಅವಳನ್ನು ಮೊದಲಿನಂತೆಯೇ ಭಾವಿಸಿದರು. ಅವಳ ಆಹಾರದಲ್ಲಿ ಯಾವುದೇ ವ್ಯತ್ಯಾಸ ಮಾಡಲಿಲ್ಲ. ಸ್ನೇಹಿತೆಯರು ಕೂಡಾ ಶ್ವೇತಾಳನ್ನ ಪ್ರತ್ಯೇಕಿಸಲಿಲ್ಲ. ಮೊದಲಿನ ಹಾಗೆಯೇ ಅವಳ ಜೊತೆ ಒಡನಾಟ ಮುಂದುವರಿಸಿದರು. ಶ್ವೇತಾ ಯಾವುದೇ ಮಾನಸಿಕ ಒತ್ತಡಕ್ಕೆ ಒಳಗಾಗಲಿಲ್ಲ. ಚಿಕಿತ್ಸೆಗೆ ಬಹಳ ಚೆನ್ನಾಗಿ ಸ್ಪಂದಿಸಿದಳು, ಹಾಗೆಯೇ ಸಂತೋಷವಾಗಿ ಬಾಳಿದಳು.

ಶುಭ್ರಳ ವಿಷಯದಲ್ಲಿ ಹೀಗಾಗಲಿಲ್ಲ. ಅವಳ ತಂದೆ–ತಾಯಿಯರು ಆತಂಕಕ್ಕೆ ಒಳಗಾದರು. ವೈದ್ಯರನ್ನು ಸಂಪರ್ಕಿಸಲು ಹಿಂಜರಿದರು. ಶುಭ್ರಳ ಸ್ನೇಹಿತೆಯರು ಅವಳನ್ನು ಪ್ರತ್ಯೇಕಿಸಲು ಶುರುಮಾಡಿದರು. ಅವಳನ್ನು ಮುಟ್ಟಲು ಅವಳೊಂದಿಗೆ ಮಾತನಾಡುಲು, ಊಟ ಮಾಡಲು ಹಿಂಜರಿದರು. ಅವರಿವರ ಮಾತನ್ನು ಕೇಳಿ ಶುಭ್ರ ತನ್ನ ಆಹಾರದಲ್ಲಿ ವ್ಯತ್ಯಾಸ ಮಾಡಿದಳು. ಹಲವರು ಅವಳಿಗೆ ಕುಷ್ಠರೋಗ ಉಂಟು, ಮತ್ತೆ ಕೆಲವರು ಚರ್ಮದ ಕ್ಯಾನ್ಸರ್ ಉಂಟು ಎಂದು ಹೇಳಲು ಶುರುಮಾಡಿದರು. ಇನ್ನೂ ಕೆಲವರಿಗೆ ಅವಳ ಮದುವೆಯ ಬಗ್ಗೆ ಚಿಂತೆ. ಇದರಿಂದ ಶುಭ್ರಳು ಮಾನಸಿಕ ಒತ್ತಡಕೆ ಒಳಗಾದಳು.

ವಿದ್ಯಾಭ್ಯಾಸದಲ್ಲಿ ಕೂಡಾ ತೊಂದರೆ ಉಂಟಾಯಿತು. ಅವಳು ಸಾಮೂಹಿಕ ಕಾರ್ಯಕ್ರಮಗಳಿಗೆ ಹೋಗುವುದನ್ನು ನಿಲ್ಲಿಸಿದಳು. ಅವಳ ತಂದೆ – ತಾಯಿಗೆ ಬಹಳ ಚಿಂತೆಯಾಯಿತು. ಹೀಗೆ ಇರುವಾಗ

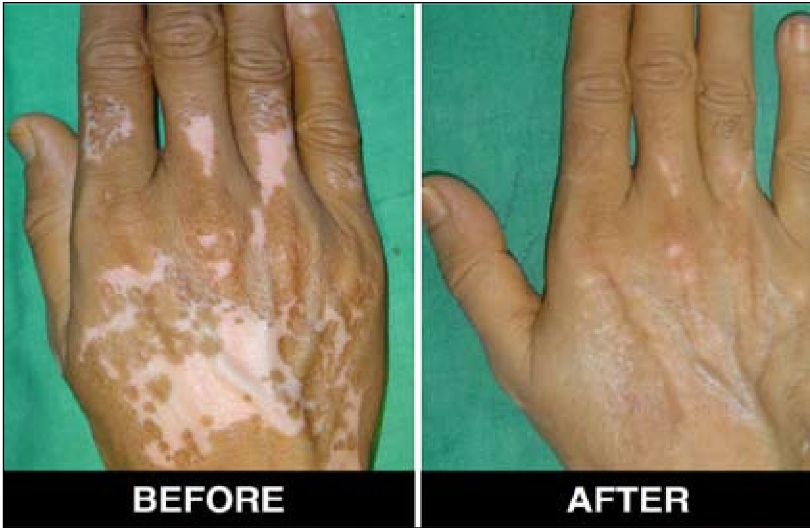


ಶುಭ್ರ ಒಮ್ಮೆ ಪತ್ರಿಕೆಯಲ್ಲಿ ತೊನ್ನು ಬಗೆಗಿನ ಲೇಖನವನ್ನು ಓದಿದಳು. ಇದಕ್ಕೆ ಚಿಕಿತ್ಸೆ ಉಂಟು ಎಂದು ಅವಳಿಗೆ ತಿಳಿಯಿತು. ತಕ್ಷಣ ಅವಳು ವೈದ್ಯರನ್ನು ಸಂಪರ್ಕಿಸಿದಳು. ವೈದ್ಯರಿಂದ ಇನ್ನೂ ಹೆಚ್ಚು ಅರಿವು ತಿಳಿದಳು, ಚಿಕಿತ್ಸೆ ಪ್ರಾರಂಭಿಸಿದಳು.

ಶುಭ್ರ ತಾನು ಹಿಂದೆ ಹೇಗೆ ಇದ್ದೆ, ಕೇವಲ ಚರ್ಮದ ಬಣ್ಣ ಬದಲಾವಣೆಯಿಂದಾಗಿ ತನ್ನ ಜೀವನದಲ್ಲಿ ಇಷ್ಟೊಂದು ವ್ಯತ್ಯಾಸವಾಯಿತೆಂದು ಚಿಂತಿಸಿದಳು. ತಾನು ಮೊದಲಿನಂತೆಯೇ ಆಗಬೇಕು ಎಂದು ನಿರ್ಧರಿಸಿದಳು. ಮನಸ್ಸಿದ್ದರೆ ಮಾರ್ಗ ಎಂಬಂತೆ ಅವಳು ಅಂದಿನಿಂದ ಸಮಾಜದ ಪ್ರಶ್ನೆಗಳಿಗೆ ಗಮನ ಕೊಡಲಿಲ್ಲ. ತನ್ನಂತೆ ಇರುವ ಕೆಲವು ವ್ಯಕ್ತಿಗಳನ್ನು ಭೇಟಿ ಮಾಡಿದಳು. ಅವರವರ ಅನುಭವವನ್ನು ಅವರು ಹಂಚಿಕೊಂಡರು. ಅವಳು ತನ್ನಂತೆಯೇ ಇರುವ ವ್ಯಕ್ತಿಗಳಿಗೆ ಏಕೆ ಸಹಾಯಮಾಡಬಾರದೆಂದು ಯೋಚಿಸಿ, ತೊನ್ನು ಸ್ವಯಂ ಸಹಾಯ ಗುಂಪನ್ನು ಶುರುಮಾಡಿದಳು. ಇದರ ಮೂಲಕ ಕೇವಲ ತೊನ್ನು ರೋಗ ಪೀಡಿತರಿಗಲ್ಲದೆ ಸಮಾಜಕ್ಕೂ ಕೂಡಾ ತೊನ್ನು ರೋಗದ ಬಗ್ಗೆ ಅರಿವು ಮೂಡಿಸುವಲ್ಲಿ ಯಶಸ್ವಿಯಾದಳು.

ಶ್ವೇತಳ ವಿಷಯದಲ್ಲಿ ಸಮಾಜ ಅವಳಿಗೆ ಪೂರಕವಾಗಿ ನಿಂತು ಅವಳಿಗೆ ಸಹಾಯ ಮಾಡಿತು. ಇದರಿಂದ ಶ್ವೇತಳ ಕಾಯಿಲೆ ಉಲ್ಬಣಗೊಳ್ಳಲಿಲ್ಲ, ಅವಳು ಸಂತೋಷವಾಗಿ ಇದ್ದಳು. ಆದರೆ ಶುಭ್ರಳ ವಿಷಯದಲ್ಲಿ ಹೀಗೆ ಆಗಲಿಲ್ಲ, ಆದರೆ ಶುಭ್ರ ಇದರಿಂದ ವಿಚಲಿತವಾಗಲಿಲ್ಲ. ತಾನು ಸ್ವಯಂ ಮೇಲೆ ಬಂದಳು. ಹಾಗೆ ರೋಗಿಗಳು ಅಷ್ಟೇ, ಕಾಯಿಲೆಯಿಂದ ವಿಚಲಿತಗೊಳ್ಳದೆ ಸರಿಯಾದ ಮಾಹಿತಿ ಪಡೆದು ಅದರ ಜೊತೆಗೆ ಸಂತೋಷವಾಗಿ ಬಾಳಬೇಕು.

ತೊನ್ನು ಕಾಯಿಲೆಗೆ ಇರುವ ಇತಿಹಾಸದಂತೆ ಅದರ ಜೊತೆಗೆ ಅಂಟಿಕೊಂಡಿರುವ ಕಳಂಕಕ್ಕು ಇತಿಹಾಸವಿದೆ. ಹಿಂದಿನ ಕಾಲದಲ್ಲಿ ತೊನ್ನು ರೋಗವನ್ನು ಕುಷ್ಠರೋಗ ಎಂದು ಕರೆಯಲಾಗುತಿತ್ತು ಎನ್ನಲಾಗಿದೆ. ಅದು ಇಂದಿಗೂ ಕೂಡಾ ತಪ್ಪು ಕಲ್ಪನೆಯಾಗಿದೆ. ತೊನ್ನು ನಮ್ಮ



ಸರ್ಕಾರ ತೊನ್ನು ಚಿಕಿತ್ಸೆಗೆ, ಅದರ ಬಗೆಗಿನ ತಪ್ಪು ಕಲ್ಪನೆಗಳ ನಿವಾರಣೆಗೆ ಯೋಜನೆಗಳನ್ನು ಆರಂಭಿಸಬೇಕು. ಸಾಮಾಜಿಕ ಜಾಲತಾಣಗಳಲ್ಲಿ ಇದರ ಬಗ್ಗೆ ಹೆಚ್ಚು ಅರಿವು ಮೂಡಿಸಬೇಕು. ವರ್ಣ ಬೇಧ ಎಂಬುದು ಮೊದಲಿನಿಂದಲೂ ಅಂಟಿಕೊಂಡಿರುವ ಕಳಂಕವಾಗಿದೆ. ಆದನ್ನು ನಿವಾರಣೆ ಮಾಡುವುದು ಪ್ರತಿಯೊಬ್ಬರ ಕರ್ತವ್ಯ. ಸಮಾಜದಲ್ಲಿ ಕಪ್ಪು ವರ್ಣದವರನ್ನು ಬೇಧಿಸುವುದುಂಟು ಬಿಳಿ ವರ್ಣದವರನ್ನು ಬೇಧಿಸುವುದುಂಟು, ಎಲ್ಲವೂ ನಾವು ನೋಡುವ ದೃಷ್ಟಿಯಲ್ಲಿ ಇರುತ್ತದೆ. ನಾವು ಜಗತ್ತನ್ನು ನೋಡುವ ದೃಷ್ಟಿಯನ್ನು ಬದಲಾಯಿಸಬೇಕು ತೊನ್ನು ರೋಗಿಗಳು ತಮ್ಮನ್ನು ತಾವು ನೋಡುವ ದೃಷ್ಟಿಯನ್ನು ಬದಲಾಯಿಸಿಕೊಳ್ಳಬೇಕು.

ದೇಹದಲ್ಲಿ ಪ್ರತಿವಸ್ತುಗಳು ಉತ್ಪನ್ನವಾಗಿ ಜೀವ ಕಣಗಳು ನಾಶವಾಗುವುದರಿಂದ ಬರುವ ತೊಂದರೆ. ಕುಷ್ಠರೋಗ ಎನ್ನುವುದು ಮೈಕ್ರೋಬ್ಯಾಕ್ಟರಿಯಮ್ ಲೆಪ್ರ ಎಂಬ ಕ್ರಿಮಿಯಿಂದ ಬರುವ ತೊಂದರೆ. ತೊನ್ನು ರೋಗ ಸಾಂಕ್ರಾಮಿಕ ರೋಗವಲ್ಲ. ಅದು ಒಬ್ಬರಿಂದ ಒಬ್ಬರಿಗೆ ಹರಡುವುದಿಲ್ಲ. ಈ ರೋಗ ಪೀಡಿತರನ್ನು ಪ್ರತ್ಯೇಕವಾಗಿ ನೋಡಬಾರದು. ಅವರೊಂದಿಗೆ ಆಟ, ಒಡನಾಟ ಮಾಮೂಲಿಯಾಗಿ ಇರಬೇಕು.

ತೊನ್ನು ಕಳೆದ ಜನ್ಮದಲ್ಲಿ ಮಾಡಿಡ ತಪ್ಪುಗಳಿಗೆ ಶಿಕ್ಷೆ, ದೇವರು ಕೊಟ್ಟ ಶಾಪ ಎಂಬಂತ ತಪ್ಪು ಕಲ್ಪನೆ ಕೆಲವರಲ್ಲಿ ಉಂಟು .ಯಾವುದೇ ಕಾಯಿಲೆ ಯಾವುದೇ ತಪ್ಪಿಗೆ ಶಿಕ್ಷೆಯಲ್ಲ, ಪೂರ್ವ ಜನ್ಮದ ಇರುವಿಕೆಯ ಬಗ್ಗೆಯೇ ಅಸ್ಪಷ್ಟತೆ ಇರುವಾಗ, ಇನ್ನೂ ಅದರಲ್ಲಿನ ತಪ್ಪು ಸರಿಗಳ ಬಗ್ಗೆ ಚರ್ಚೆ ಬೇಕೇ. ಪೂರ್ವ ಜನ್ಮದ, ಮುಂದಿನ ಜನ್ಮದ ಚಿಂತೆ ಬಿಟ್ಟು ಈಗ ಇರುವ ಮನುಷ್ಯ ಜನ್ಮದಲ್ಲಿ ಎಲ್ಲರನ್ನು ಸಮಾನವಾಗಿ ಪ್ರೀತಿಯಿಂದ ನೋಡಿ ಇರುವ ಜನ್ಮಕ್ಕೆ ಅರ್ಥ ಕಲ್ಪಿಸೋಣ.

ಇನ್ನು ಆಹಾರದ ವಿಷಯಕ್ಕೆ ಸಂಬದಿಸಿದಂತೆ ಹೇಳುವುದಾದರೆ, ಕೆಲವರಲ್ಲಿ ಹಾಲು ಸಿಟ್ರಸ್ ಹಣ್ಣುಗಳು (ರಸಭರಿತ ಹಣ್ಣುಗಳನ್ನು) ಸೇವಿಸಿದರೆ ತೊನ್ನು ರೋಗ ಉಲ್ಬಣಿಸುವುದು ಎಂಬ ಕಲ್ಪನೆ ಉಂಟು. ಯಾವುದೇ ಆಹಾರ ಪದಾರ್ಥದಿಂದ ತೊನ್ನು ಉಲ್ಬಣಗೊಳ್ಳುವುದರ ಬಗ್ಗೆ ನಿಖರವಾದ ವೈಜ್ಞಾನಿಕ ಆಧಾರಗಳಿಲ್ಲ. ಚರ್ಮದಲ್ಲಿನ ಯಾವುದೇ ಕಾಯಿಲೆಗೆ ಪೌಷ್ಟಿಕ ಆಹಾರದ ಸೇವನೆ ಅಗತ್ಯ. ಇನ್ನೂ ಮದುವೆಗೆ ಸಂಬಂಧಿಸಿದಂತೆ ಹೇಳುವುದಾದರೆ ಇದನ್ನು ಕುರಿತಾದ ಸಮಸ್ಯೆಗಳು ಮಹಿಳೆಯರಲ್ಲಿ ಹೆಚ್ಚಾಗಿ ಕಾಣುತ್ತವೆ. ತೊನ್ನು ಇರುವ ಮಹಿಳೆಯರನ್ನು ವಿವಾಹವಾಗಲು ಸಮಾಜದಲ್ಲಿ ಹಿಂಜರಿಯುವುದುಂಟು. ಮದುವೆಗೆ ಬಿಳಿ ವರ್ಣದ ಹುಡುಗಿಯರನ್ನು ಹುಡುಕುವ ಸಮಾಜದಲ್ಲಿ ಅತಿ ಬಿಳಿ

ವರ್ಣದ ಹುಡುಗಿಯನ್ನು ಮದುವೆಯಾಗುದರಲ್ಲಿ ತೊಂದರೆಯೇನು?

ಇನ್ನೂ ತೊನ್ನು ಇರುವ ಮಕ್ಕಳು ಬುದ್ಧಿಮಾಂದ್ಯ ಮಕ್ಕಳು ಎಂಬ ತಪ್ಪು ಪರಿಕಲ್ಪನೆ ಉಂಟು. ಬುದ್ಧಿವಂತಿಕೆಗೂ ಚರ್ಮದ ವರ್ಣಕ್ಕೂ ಯಾವುದೇ ರೀತಿಯ ಸಂಬಂಧವಿಲ್ಲ. ಬುದ್ಧಿಮಾನ್ಯತೆಗೆ ಬೇರೆ ಕಾರಣಗಳುಂಟು.

ತೊನ್ನು ಒಂದು ವಿಧವಾದ ಚರ್ಮದ ಕ್ಯಾನ್ಸರ್ ಅಲ್ಲ. ಕ್ಯಾನ್ಸರ್ ಕಾಯಿಲೆಗೂ, ತೊನ್ನು ರೋಗಕ್ಕೂ ಯಾವುದೇ ರೀತಿಯ ಸಂಬಂಧವಿಲ್ಲ. ಎಲ್ಲಾ ಬಿಳಿಯ ಮಚ್ಚೆಗಳು ತೊನ್ನುಗಳಲ್ಲ, ಬಿಳಿಯ ಮಚ್ಚೆಗಳಲ್ಲಿ ಹಲವು ವಿಧಗಳು, ಹಲವು ಕಾರಣಗಳು ಉಂಟು. ಬಿಳಿಯ ಮಚ್ಚೆ ಇದ್ದಲಿ ವೈದ್ಯರಲ್ಲಿ ಹೋಗಿ ಪರಿಶೀಲನೆ ಮಾಡಿಸಬೇಕು. ರೋಗಿಗಳೇ ಸ್ವತಃ ನಿರ್ಧಾರಕ್ಕೆ ಬರಬಾರದು. ತೊನ್ನು ರೋಗದಿಂದ ದೇಹದಲ್ಲಿನ ಬೇರೆ ಅಂಗಾಂಗಗಳಿಗೆ ಯಾವುದೇ ತೊಂದರೆ ಉಂಟಾಗುವುದಿಲ್ಲ. ತೊನ್ನು ಇರುವ ವ್ಯಕ್ತಿಗಳ ಆಯಸ್ಸಿನಲ್ಲಿ, ಜೀವಿತಾವಧಿಯಲ್ಲಿ ಯಾವುದೇ ವ್ಯತ್ಯಾಸವಿಲ್ಲ. ಸಾಮಾನ್ಯ ಜನರಿಗೆ ಇರುವ ಹಾಗೆಯೇ ಅವರಿಗೂ ಮಾಮೂಲಿಯ ಜೀವಿತಾವಧಿ ಉಂಟು.

ಇನ್ನೂ ಇದರ ಚಿಕಿತ್ಸೆಯ ಬಗ್ಗೆ ಇರುವ ತಪ್ಪು ಕಲ್ಪನೆಗಳ ಬಗ್ಗೆ ಹೇಳುವುದಾದರೆ

- ತೊನ್ನು ರೋಗಕ್ಕೆ ಉತ್ತಮ ಚಿಕಿತ್ಸೆ ಉಂಟು.
- ಇದು ಗುಣವಾಗಬಲ್ಲ ಕಾಯಿಲೆ.
- ವಿವಿಧ ಚಿಕಿತ್ಸೆಗಳು ಲಭ್ಯ.
- ಮೆಡಿಕಲ್
- ಫೋಟೋತೆರೆಫಿ.
- ಸರ್ಜಿಕಲ್ ಚಿಕಿತ್ಸೆ.

ಚಿಕಿತ್ಸೆ ಅನುಕರಣೆ ಬಹಳ ಮುಖ್ಯ. ಚಿಕಿತ್ಸೆಗೆ ಬದ್ಧರಾಗಿರಬೇಕು.

HIPPOCRATES ತನ್ನ ಬರಹಗಳಲ್ಲಿ ಈ ರೋಗ, ಆರಂಭಿಕ ಹಂತದಲ್ಲಿ ಇರುವಾಗ ಚಿಕಿತ್ಸೆ ಶುರುಮಾಡಿದರೆ ಚಿಕಿತ್ಸೆ ಸುಲಬವಾಗುತ್ತದೆ ಎಂದು ಹೇಳಿದ್ದಾರೆ. ನಿಜ, ಆರಂಭಿಕ ಹಂತದಲ್ಲಿ ಚಿಕಿತ್ಸೆ ಶುರು ಮಾಡಿದರೆ ಚಿಕಿತ್ಸೆ ಸುಲಬವಾಗುತ್ತದೆ. ಅದು ದೇಹದ ಇತರ ಭಾಗಗಳಿಗೆ ಹರಡುವುದದನ್ನು ತಡೆಯಲು ಸಾಧ್ಯ ಉಂಟು. ಇನ್ನೂ ಬ್ಯೂಟಿ ಪಾರ್ಲರ್‌ಗಳಲ್ಲಿ ತೊನ್ನು ರೋಗಕ್ಕೆ ಯಾವುದೇ ಚಿಕಿತ್ಸೆ ಇಲ್ಲ. ದೇಹದಲ್ಲಿ ಬಿಳಿ ಮಚ್ಚೆ ಇದ್ದಲ್ಲಿ ಆದಷ್ಟು ಬೇಗ ವೈದ್ಯರನ್ನು ಸಂಪರ್ಕಿಸಿ. ತೊನ್ನು ಇರುವ ರೋಗಿಗಳು ಯಾವುದೇ ಸಾಮಾಜಿಕ ಕಾರ್ಯಕ್ರಮಗಳಲ್ಲಿ ಕೆಲಸದ ಸ್ಥಳಗಳಲ್ಲಿ, ಇತರರೊಂದಿಗೆ ಬೆರೆಯಲು ಹಿಂಜರಿಯುವುದುಂಟು. ಇದರಿಂದ ಅವರ ವೈಯಕ್ತಿಕ, ಸಾಮಾಜಿಕ ಸಂಬಂಧಗಳಲ್ಲಿ ಬಿರುಕು ಬರುವುದು ಉಂಟು. ಎಷ್ಟೋ ರೋಗಿಗಳು ಮಾನಸಿಕ ಒತ್ತಡಕ್ಕೆ ಒಳಗಾಗಿ ಇದಕ್ಕೆ ಚಿಕಿತ್ಸೆ ಇಲ್ಲ ಎಂದು ಭಾವಿಸಿ ಆತ್ಮಹತ್ಯೆಗೆ ಪ್ರಯತ್ನಿಸುವುದುಂಟು. ಇದಕ್ಕೆಲ್ಲ ಕಾರಣ ನಮ್ಮ ಸಮಾಜ. ಬಿಳಿ ವರ್ಣ ಸಮಾನತೆಯ ಸಂಕೇತ ಎಂದು ಹೇಳುವ ಸಮಾಜದಲ್ಲಿ ಅವರನ್ನು ಪ್ರತ್ಯೇಕಿಸುವುದು ಏಕೆ?

ಇದರ ಬಗ್ಗೆ ತಪ್ಪು ಕಲ್ಪನೆಗಳ ನಿವಾರಣೆಯಲ್ಲಿ ವೈದ್ಯರು ಸಹ ಪ್ರಮುಖ ಪಾತ್ರ ವಹಿಸುತ್ತಾರೆ. ವೈದ್ಯರು ರೋಗಿಗಳಿಗೆ ಹೆಚ್ಚು ಸಮಯ ತೆಗೆದುಕೊಂಡು ಕಾಯಿಲೆ ಬಗ್ಗೆ ವಿವರಿಸಿ ಅದರ ಬಗ್ಗೆ ಅರಿವು ಮೂಡಿಸಬೇಕು.

ತೊನ್ನು ಸ್ವಯಂ ಸಹಾಯ ಗುಂಪುಗಳನ್ನು ಕಟ್ಟಬೇಕು, ಇದರಲ್ಲಿ ರೋಗಿಗಳು ಅವರವರ ಅನುಭವಗಳನ್ನು ಹೇಳಿ ಒಬ್ಬರಿಗೊಬ್ಬರು ಸಹಾಯ ಮಾಡುತ್ತಾರೆ. ರೋಗಿಗಳ ಮಾನಸಿಕ ಒತ್ತಡ ಇದರಿಂದ ಕಡಿಮೆಯಾಗುತ್ತದೆ. ಹಲವಾರು ದೇಶಗಳಲ್ಲಿ ತೊನ್ನು ಚಿಕಿತ್ಸೆಗೆ ವಿಮೆ ಯೋಜನೆಗಳು ಉಂಟು.

ನಮ್ಮದೇಶದಲ್ಲಿ ಇದರ ಅನುಕರಣೆಯಾಗಬೇಕು. ಸರ್ಕಾರ ತೊನ್ನು ಚಿಕಿತ್ಸೆಗೆ, ಅದರ ಬಗೆಗಿನ ತಪ್ಪು ಕಲ್ಪನೆಗಳ ನಿವಾರಣೆಗೆ ಯೋಜನೆಗಳನ್ನು ಆರಂಭಿಸಬೇಕು. ಸಾಮಾಜಿಕ ಜಾಲತಾಣಗಳಲ್ಲಿ ಇದರ ಬಗ್ಗೆ ಹೆಚ್ಚು ಅರಿವು ಮೂಡಿಸಬೇಕು. ವರ್ಣ ಬೇಧ ಎಂಬುದು ಮೊದಲಿನಿಂದಲೂ ಅಂಟಿಕೊಂಡಿರುವ ಕಳಂಕವಾಗಿದೆ. ಅದನ್ನು ನಿವಾರಣೆ ಮಾಡುವುದು ಪ್ರತಿಯೊಬ್ಬರ ಕರ್ತವ್ಯ. ಸಮಾಜದಲ್ಲಿ ಕಪ್ಪು ವರ್ಣದವರನ್ನು ಬೇಧಿಸುವುದುಂಟು ಬಿಳಿ ವರ್ಣದವರನ್ನು ಬೇಧಿಸುವುದುಂಟು, ಎಲ್ಲವೂ ನಾವು ನೋಡುವ ದೃಷ್ಟಿಯಲ್ಲಿ ಇರುತ್ತದೆ. ನಾವು ಜಗತ್ತನ್ನು ನೋಡುವ ದೃಷ್ಟಿಯನ್ನು ಬದಲಾಯಿಸಬೇಕು ತೊನ್ನು ರೋಗಿಗಳು ತಮ್ಮನ್ನು ತಾವು ನೋಡುವ ದೃಷ್ಟಿಯನ್ನು ಬದಲಾಯಿಸಿಕೊಳ್ಳಬೇಕು. ಅವರಿಗೆ ವರ್ಣ ವ್ಯತ್ಯಾಸ ಬಿಟ್ಟು ಬೇರೆ ಯಾವುದೇ ವಿಧವಾದ ಸಮಸ್ಯೆಯಿಲ್ಲ ಎಂಬ ಅರಿವು ಮೂಡಬೇಕು.

ವಿಶಾಲವಾದ ಆಕಾಶದಲ್ಲಿ ಕಪ್ಪು ಬಿಳುಪು ಬಣ್ಣದಿಂದ ಕೂಡಿದ ಚಂದ್ರನು ಎಷ್ಟು ಸುಂದರವಾಗಿ ಕಾಣುವುದಿಲ್ಲವೇ? ಅದೇ ರೀತಿ ಈ ವಿಶಾಲವಾದ ಪ್ರಪಂಚದಲ್ಲಿ ಕಪ್ಪು ಬಿಳುಪು ಬಣ್ಣದಿಂದ ಕೂಡಿದ ವ್ಯಕ್ತಿಗಳನ್ನು ಸುಂದರ ಎಂದು ಏಕೆ ಭಾವಿಸುವುದಿಲ್ಲ.ತೊನ್ನನ್ನು ಶಾಪ ಎಂದು ಭಾವಿಸಬೇಡಿ.

ಮೇಘನಾ ಬಿ.ವಿ.
ಪಿ.ಜಿ.–II,
ಕಸ್ತೂರಿ ಬಾ ಮೆಡಿಕಲ್ ಕಾಲೇಜು,
ಮಣಿಪಾಲ್.

1st place in Vitiligo Poster Competition

ಡಾ. ವನಿತಾ ಎಂ.ಎಂ.
ಪಿ.ಜಿ.–I, ಎಸ್.ಎಸ್. ವೈದ್ಯಕೀಯ ವಿಜ್ಞಾನಗಳ ಮತ್ತು ಸಂಶೋಧನಾ ಸಂಸ್ಥೆ, ದಾವಣಗೆರೆ.

2nd place in Vitiligo Poster Competition

ವಿಟಿಲಿಗೋ ದಿನ - JUNE 25

ಪ್ರೀತಿಯನ್ನು ಹರಡಿ, ಕೈಗಳನ್ನು ಹಿಡಿದುಕೊಳ್ಳಿ

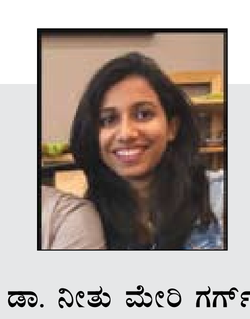
ಅದು ಶಾಪವಲ್ಲ ಅಂಗೀಕಾರದ ವಿಷಯವಾಗಿದೆ

IADVL- KN

ಏಕೆಂದರೆ ಅವರು ಜೀವನದ ಎಲ್ಲಾ ಬಣ್ಣಗಳಿಂದ ಆಶೀರ್ವದಿಸಲ್ಪಟ್ಟಿರುತ್ತಾರೆ

IADVL KN

DR. NEETHU MARY GEORGE



ಡಾ. ನೀತು ಮೇರಿ ಗರ್ಗ್
ಪಿ.ಜಿ.–II,
ಶ್ರೀ ಸಿದ್ಧಾರ್ಥ ಮೆಡಿಕಲ್ ಕಾಲೇಜು, ತುಮಕೂರು.

IADVL- KN

ಪ್ರತಿಯೊಬ್ಬರೂ ಅನನ್ಯ, ನಾನು ಅದನ್ನು ನನ್ನ ಚರ್ಮದ ಮೇಲೆ ಪ್ರದರ್ಶಿಸುತ್ತಿದ್ದೇನೆ

ಡಾ. ಪಿ. ರಾಮ ಸುಶ್ರುತ್
ಪಿ.ಜಿ.–III
ಶ್ರೀ ಬಿ.ಎಂ. ಪಾಟೀಲ್ ವೈದ್ಯಕೀಯ ವಿಜ್ಞಾನಗಳ ಹಾಗೂ ಸಂಶೋಧನಾ ಸಂಸ್ಥೆ, ವಿಜಯಪುರ.

KEEP CALM AND UNSCRAMBLE!

ANSWERS :

LINES IN DERMATOLOGY	NAMED BODIES IN DERMATOLOGY
HINDERERS LINES	PERTINAX BODIES
PASTIA LINES	GUARNIERI BODIES
BLASCKO LINES	MURIFORM BODIES
FINGERPRINT LINES	SABAROUD BODIES
MUEHRCKES LINES	ARAO-PERKIN BODIES

ANSWER FOR THE IMAGE : FLAME FIGURES

Dr. Gagana Gopal,
PG 2, MIMS,
Mandya.

We hope you have liked this effort of ours.
Mail us your feedback, queries and articles at
iadvlkn.ebulletin@gmail.com

Regards,
Editorial Team

Design : Sridhar - 9036140802

DERMACON INTERNATIONAL 2019 INDIA

Indian Mission - Global Vision

17th - 20th Jan 2019
Clarks Exotica Convention Resort & Spa, Bengaluru.

KEY HIGHLIGHTS

- The 47th Annual conference of IADVL, with an international outreach program and with a theme of "Indian mission with global vision" will bring together.
- 9000 international & national delegates.
- Around 400 national & more than 60 international faculty and experts.
- Around 150 worldwide industry participations from reputed pharmaceutical companies, lasers & dermatological technologies.
- Well-structured plenary, orations, symposia, guest lectures, debates, national quiz, award papers, free communications and posters, apart from other official programs.
- Well planned courses & workshops on dermatosurgery, aesthetic dermatology, lasers and other procedural dermatology.

CONFERENCE & CME REGISTRATION FEES

	SLAB 2 1st May to 31st Aug 2018		SLAB 3 1st Sept to 15th Dec 2018		SLAB 4 / SPOT REG 16th Dec onwards	
Delegate Category	Conference Only	CME + Conference	Conference Only	CME + Conference	Conference Only	CME + Conference
IADVL Members	₹ 10000	₹ 12700	₹ 11500	₹ 14500	₹ 15000	₹ 19000
Post Graduates IADVL members	₹ 7000	₹ 8500	₹ 8000	₹ 9500	₹ 10000	₹ 12500
Accompanying Person	₹ 7000	₹ 8500	₹ 8000	₹ 9500	₹ 10000	₹ 12500
Workshop Registrations fees						
Workshops	₹ 2000	N/A	₹ 2500	N/A	₹ 3000	N/A
Target Course	₹ 3000	N/A	₹ 3500	N/A	₹ 4000	N/A

INTERNATIONAL EVENTS

- 5 Sister Society has been confirmed (South Africa, Singapore, Iran, SriLanka & SARAD) we are expecting more.
- DERMACON International Quiz Competition.
- Review Article Writing. (Alternative to Essay Competition Announced Earlier)
- DERMACON International Scholarships to Young Dermatologists.
- Global Leadership Session.
- Scholarship Program for International Delegates.

Dr S. Sacchidanand
Organising Chairperson

Dr R. Raghunatha Reddy
Organising Secretary

Dr Savitha
Treasurer

Dr Venkataram Mysore
International Liaison Chairperson

Dr D.A. Satish
Organising Co-Chair

www.dermaconinternational2019.com