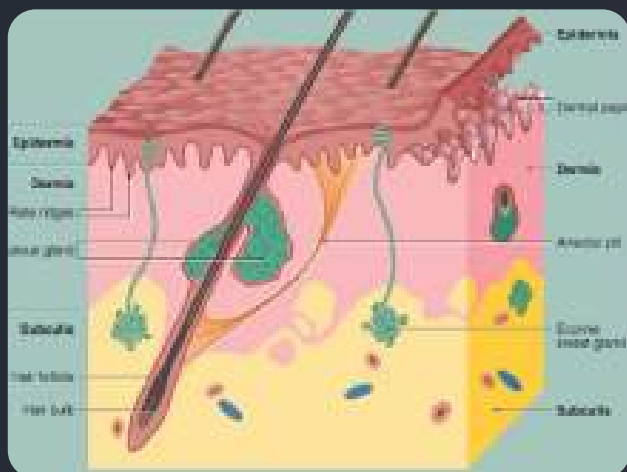


2025

NEWSLETTER



IADVL SIG ACNE & APPENDAGEAL DISORDERS (IADVL Academy)



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Foreword

It is with great pleasure that we present to you the first volume (2025) of our Newsletter (SIG Acne and Appendageal Diseases) where we bring you expert perspectives from across the various diseases.

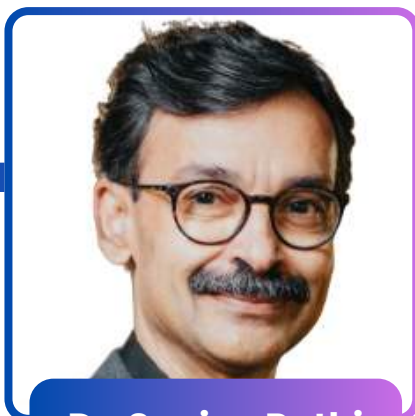
In dermatology, it is often said that the real challenge lies not in diagnosing the disease but in guiding the patient through it. This issue is a reflection of that philosophy: practical, empathetic, and rooted in the everyday realities we face in clinical practice.

The present issue focusses more on practical tips in day-to-day practice to manage efficiently the diseases like Hidradenitis suppurativa, rosacea flares, bromhidrosis, distinguishing seborrheic dermatitis from rosacea, handling miliaria in adults, Fox-Fordyce disease. The journal scan to keep evidence edge sharp, also the part of this issue. We have also included a quiz to titillate your grey cells.

We are grateful to our editorial team, Dr. Nidhi Shah and Dr. Gulrez Tyebkhan, who had worked very hard to bring this newsletter in shape.

And last but not the least, a special thanks to all our SIG members who have contributed to present issue.

Wish you all a happy reading!



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Hidradenitis Suppurativa: My Go-To Counselling Tips for First-Time Diagnoses

Dr. Nina Madnani, Mumbai

1. What is Hidradenitis Suppurativa (HS)?

- HS is a chronic relapsing disease where symptoms can come and go.
- It is often missed, and can last for years before it is correctly diagnosed.
- It starts as painful lumps under the skin, in areas of friction where skin rubs together (armpits, groin, buttocks, under breasts, or even under an abdominal fold).
- In these areas, the hair follicles and apocrine sweat glands, get swollen and painful.

2. Symptoms

- Episodes may start as firm lumps and progress to painful nodules or abscesses, and eventually become draining lesions
- Tunnels (sinus tracts) often develop under the skin.
- Disfiguring scarring and skin changes are the late outcome.

3. Causes and Risk Factors

- Although the exact cause is unknown, immune system dysfunction and genetics play a role.
- The hair follicles in the frictional areas are hypothesised to have a defective barrier function.
- Poor hygiene as a cause is a myth.
- Risk factors:
 - Smoking and obesity can worsen the condition.
 - It usually starts after puberty, and hormones seem to play a role

4. Diagnosis

- Diagnosis is usually clinical based on a history of multiple painful boils in the friction areas within 6 months
- There is no specific test, but sometimes swabs, biopsies, or imaging (ultrasonography or MRI) may be done to rule out other conditions.
- Patients with HS often have nodulocystic or moderately severe acne.

5. Psychological and Social Impact

- HS is a debilitating disease and can cause depression, anxiety, and social isolation.
- Regular counselling is often advised.
- Support groups are useful in motivating patients to share their experience, and get solace.

6. Treatment Options

Tailored to severity (Hurley stages I–III)

Lifestyle Measures

- Weight management, smoking cessation may help in many individuals
- Wearing loose clothing, maintaining skin care, avoiding deodorants, and laser hair reduction helps to reduce the episodes.

Medical Treatment

- Topical clindamycin or benzoyl peroxide for mild disease.
- Chlorhexidine scrub or benzoyl peroxide washes twice a day
- Oral antibiotics (e.g., tetracyclines) for milder flares, and clindamycin with/without Rifampicin) for more severe disease when indicated.
- Hormonal therapy (especially for women) is often recommended.
- Biologic therapies (e.g., adalimumab / infliximab / secukinumab) for moderate-to-severe cases.
- Pain control.

Procedural Treatment

- Incision and drainage for acute abscesses (not curative).
- Laser therapy or wide surgical excision for advanced disease.
- Laser hair reduction for the friction sites

7. Long-Term Outlook

- HS is a chronic condition with no permanent cure yet, but symptoms can be managed with proper care, to improve the patient's quality of life.
- Early diagnosis and intervention, with long-term follow-up is the key to minimize complications and scarring.

COUNSELLING TIPS FOR PATIENTS WITH HS

1. At the initial consult, assess and build a rapport with the patient

- Greet warmly and empathize with the patient about their condition
- Take a careful history covering various aspects of the disease eg duration, symptoms, areas involved, past treatment done, medications on at present, response to treatment
- Carry out a complete examination to assess and classify the disease severity i.e. the Hurley stage
- Evaluate the disease effect on the patient's quality of life

2. Educate the patient about the disease

- HS is a long-term recurring disease where symptoms can come and go.
- b. It is often missed, and can last for years before it is correctly diagnosed.
- It starts as painful lumps under the skin, in areas of friction where skin rubs together (armpits, groin, buttocks, under breasts, or even under an abdominal fold).
- In these areas, the hair follicles and sweat glands, get swollen and painful
- It is not related to poor hygiene, and is not contagious

3. Discuss how the disease severity is evaluated

- Explain the various Hurley stages with pictures
- Explain which stage the patient falls in.
- Emphasize the need for early treatment to prevent progression and scarring

4. Explain the various treatment options available and applicable

- Mild disease (Hurley stage I: Topical antibacterials, antiseptic or benzoyl peroxide washes, avoidance of deodorant application, lifestyle changes
- Moderate to severe (Hurley stage II and III): Systemic antibiotics, which may include tetracyclines, clindamycin, rifampicin), hormonal therapy for women, biologics (adalimumab/infliximab/secukinumab); surgical options eg deroofing/excision/incision and drainage

5. Engage the patient in shared decision making

- Discuss risks and benefits of each clearly with the patient, and recommend what you feel is in the best interest of the patient
- Emphasize about monitoring and regular follow-ups, and document flares at each visit
- Plan the treatment
- Emphasize the need for realistic expectations
- Coordinate with other specialists when need arises eg with endocrinologist/surgeon/gynecologist/physician

6. Evaluate the psychological impact

- Screen for anxiety, suicidal ideation, depression and psychiatrist/counsellor reference when required
- Project empathy at each visit
- Provide details of patient support groups, medical information sites to the patient for easy referral

PATIENT SUPPORT GROUPS / EDUCATION-From Internet

1. American Academy of Dermatology (AAD)

- Website: www.aad.org
- Direct link: HS patient page

2. NHS UK – Hidradenitis Suppurativa

- Website: www.nhs.uk

3. DermNet NZ

- Website: www.dermnetnz.org
- Offers images, symptoms, and treatment options in clear language.

4. Mayo Clinic

- Website: www.mayoclinic.org
- Direct link: [HS overview](#)

5. Hidradenitis Suppurativa Foundation (HS Foundation)

- Website: www.hs-foundation.org
- Offers detailed patient guides, research updates, and support networks.

Online Support Groups & Communities

1. Hope for HS (USA)

- Website: www.hopeforhs.org
- Patient-run support organization with chapters, educational materials, and events.

2. HS Connect

- Website: www.hsconnect.org
- Founded by patients provides real-life coping strategies, advocacy, and news.

3. Reddit – r/Hidradenitis

- Website: www.reddit.com/r/hidradenitis
- Peer-to-peer support; not a substitute for medical advice, but often helpful emotionally.

4. Facebook Groups

- Search: “Hidradenitis Suppurativa Support” or “HS Warriors”
- Many private and public Facebook groups offer emotional support and shared experiences.

5. Inspire.com – HS Support Community

- Website: www.inspire.com
- Patient-centered forum with health-based communities.

Mental Health & Coping

- Mind.org.uk – www.mind.org.uk (UK-based)
- NAMI (National Alliance on Mental Illness) – www.nami.org (USA)
- Psychological support is essential due to the emotional burden of HS.

Fox Fordyce Disease: How to Clinically Suspect Before Confirming

Dr. Kavita Poonia, Bhatinda

Introduction

Fox-Fordyce disease, also known as apocrine miliaria, is a rare, chronic inflammatory disorder of the apocrine glands, primarily affecting young women. It typically presents as pruritic, folliculocentric papules in the axillae, but may also appear in other apocrine-rich areas. First described in 1902 by George Henry Fox and John Addison Fordyce, diagnosis is clinical, as no specific diagnostic tests are available.

Clinical Clues – What I Look for in Fox-Fordyce Disease

Patient Profile

- Most commonly seen in post-pubertal women aged 13–35 years.
- Rare in pre-pubertal children, postmenopausal women, and males.

Lesion Morphology

- Dome-shaped, smooth, uniform follicular or perifollicular papules (2–3 mm).
- Color varies: flesh-colored, reddish-brown, or slightly yellow.

Anatomic Distribution

- Affects apocrine-rich areas: axillae, areolae, perianal and genital regions.
- Less commonly: lips, umbilicus, sternum, perineum, upper medial thighs.

Pattern Recognition

- Linear or patterned distribution when skin is stretched.
- Typically shows bilateral involvement in symmetrical areas.

Chronicity Indicators

- Long-standing disease may lead to lichenification, hyperpigmentation, and skin thickening from scratching.

Associated Features in Severe Cases

- May see localized anhidrosis, and sparse, brittle, or reduced hair (hypotrichosis) in affected areas.

Exacerbating factors

- Hyperhidrosis, sweating, stress, humid weather and anxiety.
- History of laser hair reduction (follicular infundibulum damage from laser irradiation leading to keratinocyte dysmaturation and subsequent keratin plugging).
- Premenstrual flare-ups (improvement seen during pregnancy, postmenopause, and with oral contraceptive pills)

Differentiating features from clinical mimickers

Condition	Key Features	Distinguishing from Fox-Fordyce Disease
Folliculitis	Papules, pustules, erythema, and tenderness.	Presence of pustules and inflammation absent in Fox-Fordyce disease.
Hidradenitis Suppurativa	Involves apocrine glands with abscesses, draining sinuses, and scarring.	Fox-Fordyce lacks abscess formation and significant scarring.
Pseudofolliculitis	Occurs in shaved/waxed areas with ingrown hairs.	Fox-Fordyce is not related to shaving and lacks ingrown hairs.
Acanthosis Nigricans	Velvety, hyperpigmented plaques typically in flexural areas.	velvety plaques are absent in Fox-Fordyce disease.
Miliaria (Rubra/Profunda)	Vesicular or papular eruptions due to eccrine duct occlusion; can occur anywhere with eccrine glands.	Fox-Fordyce is limited to apocrine-rich areas and not vesicular.
Granular Parakeratosis	Hyperkeratotic brown-red papules, often coalescing into plaques in intertriginous areas; associated with acanthosis.	More hyperkeratotic and plaque-forming than typical Fox-Fordyce lesions.
Graham-Little-Piccardi-Lasseur Syndrome	Features lichen planopilaris, nonscarring alopecia, commonly involving the axillae.	Associated with alopecia and lichen planus, which are absent in Fox-Fordyce disease.

Investigation

- Dermoscopy: shows follicle-centered papules, traumatized terminal hairs, and blackheads.
- Histopathology includes dilatation of the follicular infundibula with hyperkeratosis, acanthosis and spongiosis of the infundibular epithelium and perifollicular infiltration of lymphocytes and foamy histiocytes, leading to hair loss
- High-definition in vivo optical coherence tomography (HD-OCT) provides axial (slice) imaging that reveals dilated ductal structures surrounded by a dark rim

Management

There is no established treatment protocol for Fox-Fordyce disease. Various therapies have shown inconsistent results across small patient groups, and symptoms often recur after discontinuing treatment.

Differentiating features from clinical mimickers

Treatment Category	Modality	Remarks
First-Line	Topical corticosteroids	Twice daily application initially; taper with improvement. Use low-potency to avoid atrophy.
	Topical calcineurin inhibitors: (Tacrolimus/pimecrolimus)	Reduce inflammation without causing atrophy; moderately effective.
	Topical clindamycin	Used twice daily. Mechanism unclear
	Topical retinoids (Tretinoin/adapalene)	Reduce follicular plugging; may cause irritation.
	Oral isotretinoin	Shown benefit in some refractory cases
Second line	Surgical excision, fractional lasers-1550 nm erbium-glass, pulsed dye laser, botulinum toxin injections, phototherapy, electrocoagulation, copper vapor, CO2 laser, liposuction-assisted curettage, and microwave technology.	Reserved for severe and refractory cases unresponsive to first-line therapy

Counselling and Education for Patients with Fox-Fordyce Disease

- Fox-Fordyce disease is a rare, chronic not contagious skin condition that mainly affects young women,
- Presenting as itchy, skin-coloured or dark bumps in areas rich in apocrine glands, (underarms, pubic region, and around the nipples).
- Cause significant discomfort due to persistent itching and cosmetic concerns.
- Avoid triggers such as stress, humid environments, and tight or occlusive clothing, and excessive scratching to prevent skin thickening, hyperpigmentation, and secondary infections.
- No definitive cure for Fox-Fordyce disease, symptom management through topical or oral medications and in some cases, laser therapy or surgical intervention. However, recurrence may occur if treatment is discontinued.
- Regular follow-up is important for monitoring the condition and adjusting treatment as needed.

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Miliaria Management for Adults: Beyond just cooling the Skin

Dr Abhineetha Hosthota, Bengaluru

Introduction

Miliaria, commonly called heat rash or prickly heat, is a familiar nuisance for those in hot, humid environments. It results from blocked eccrine sweat ducts, causing sweat to leak into the skin layers, forming vesicles. While often self-limiting, its recurring nature in certain populations calls for practical, tailored management. This piece provides a clinician's perspective on diagnosing and managing miliaria in adults with insights rooted in both research and experience.

Etiology

Adult miliaria is triggered by eccrine duct occlusion, which often stems from excessive sweating.

Common precipitating factors include:

1. **Environmental:** Hot, humid weather
2. **Medical:** Febrile illnesses
3. **Mechanical/Occupational:**
 - Skin occlusion from tight clothing, PPE (like N95 masks), or transdermal patches
 - Prolonged wear of heat-retaining uniforms (e.g., flame-resistant clothing [as in maintenance or defense industries])
 - Occupational exposure to high ambient temperatures in professions like mining, cooking, or firefighting
4. **Physical:** Vigorous exercise
5. **Systemic or pharmacologic:** Rare conditions like Type I pseudohypoaldosteronism, or medications such as bethanechol and clonidine
6. **Post-pandemic note:** With the rise in PPE use (especially N95 masks), clinicians have seen an uptick in facial miliaria, particularly among healthcare workers

Pathophysiology

The root issue: eccrine duct obstruction, due to:

- Cutaneous debris or overhydration
- Bacterial biofilm (esp. *Staphylococcus epidermidis*)
- Occlusive skincare or clothing

Clinical Presentation

Type	Description	Sites	Symptoms
Crystallina	Tiny clear vesicles, no inflammation	Trunk, neck, head	Asymptomatic
Rubra	Red, itchy papules/vesicles ± pustules	Axillae, groin, trunk	Pruritus, burning
Profunda	Firm, skin-coloured papules	Trunk, limbs	Pruritus, sometimes anhidrosis

Diagnosis

Mainly clinical. Dermoscopy may assist (e.g., white globules with dark rings in darker skin). Rarely, biopsy is needed.

Histopathological Features:

- Miliaria crystallina: Sub corneal vesicles ± neutrophils
- Miliaria rubra: Spongiosis, intraepidermal vesicles, lymphocytes
- Miliaria profunda: Intradermal duct rupture, intense lymphocytic inflammation

Differential Diagnosis: Spot the Lookalikes

Condition	Key Differentiators
Folliculitis	Centered around hair follicles, pustular, often bacterial
Viral exanthems	Systemic symptoms, widespread rash
Contact dermatitis	Clear history of irritant/allergen exposure, typically itchy
Drug rash	Onset after new medication, may be widespread
Candidiasis (intertrigo)	Moist intertriginous areas, satellite lesions

Management: Goal: Cool, unclog, and calm the skin

General Measures

- Stay in cool, well-ventilated settings (AC, fans)
- Take frequent cool showers
- Wear light, loose cotton clothes
- Avoid heavy creams or ointments
- Maintain daily hygiene using gentle cleansers

Topical Treatments

- Calamine lotion: Soothes and reduces itch
- Low-potency steroids: For inflamed rubra (e.g., hydrocortisone 1%)
- Topical clindamycin: may be helpful in pustular forms, particularly with superimposed bacterial involvement

Systemic Treatments

- Oral antihistamines: To relieve pruritus
- Antibiotics: For bacterial superinfection (rare)
- Oral isotretinoin: Occasionally used in recurrent miliaria profunda
- Anhydrous lanolin: Barrier agent in profunda

“What I Do” – Pearls from Practice

- Educate patients early recognition prevents complications
- In recurrent cases, look for contributing medications or systemic illness
- **Prevention Hacks:**
 - Many adult patients benefit from practical strategies that go beyond textbook measures especially in occupational or post-pandemic contexts.
- **Before Exposure**
 - Apply non-comedogenic barrier creams (e.g., dimethicone) to high-friction areas to reduce mechanical irritation
 - In selected individuals with hyperhidrosis, low-strength aluminium chloride antiperspirants may reduce sweating in non-axillary areas (e.g., back, chest)
 - Use talc-free absorbent powders in skin folds or under equipment to reduce moisture retention
- **During Activity or Heat Exposure**
 - Opt for technical fabrics (e.g., moisture-wicking athletic wear) under uniforms, particularly for outdoor or industrial workers
 - Carry a spare undershirt for midday changes in high-humidity settings
 - Cool gel packs worn intermittently around the neck or under headgear help reduce core temperature
 - Use cooling towels or fans during scheduled breaks, especially in closed environments (e.g., kitchens, warehouses)
- **After Work or Exercise**
 - Rinse off sweat as soon as possible with gentle cleansing avoid over-scrubbing
 - Apply lightweight moisturizers or aloe-based gels, especially if skin feels tight or irritated
 - Soothing oatmeal baths or diluted baking soda soaks can help in more extensive cases
 - Store calamine lotion or aloe gel in the fridge for enhanced post-application cooling

High-Risk Populations & Tailored Advice

Cooks, firefighters, construction workers

- Take scheduled breaks in shaded or cooled areas
- Change sweaty clothing mid-shift
- Use absorbent powder on high-friction sites

Healthcare workers using N95 masks/PPE

- Use soft foam strips inside masks for friction reduction
- Apply light, breathable moisturizers before and after duty
- Limit unnecessary face washing to avoid overhydration
- Frequent mask breaks, barrier creams, and using breathable fabrics can help.

Prognosis & Complications

- Usually resolves with improved environmental control.

Complications (infrequent but important)

- Anhidrosis → Risk of heat exhaustion
- Secondary bacterial infection

Patient Education: Key Messages

- Keep cool and dry
- Avoid tight or synthetic clothes
- Bathe with lukewarm water regularly
- Stay hydrated and avoid unnecessary heat exposure

Final Thoughts

Miliaria may be common, but its impact especially in working adults shouldn't be underestimated. With a mix of preventive hygiene, environment control, and targeted therapies, it can be effectively managed. A bit of clinical suspicion and empathetic counselling go a long way.

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Managing Bromhidrosis: Practical Tips Without Embarrassing the Patient

Dr. Kavya Baddireddy, Vizag

Introduction

Bromhidrosis, or body odour, is a common yet sensitive condition that often affects a person's everyday life. It arises from the interaction between sweat and skin bacteria and may be influenced by physiological, lifestyle, or medical factors. Managing it effectively calls for a comprehensive strategy that integrates scientific understanding, practical treatments, and empathetic patient communication. Successful care typically involves a combination of good hygiene, topical and systemic therapies, and, when necessary, procedural options for resistant cases.⁽¹⁾

Pathophysiology – Understanding the Science Behind Body Odor

1. Sweat Gland Physiology

- a. Apocrine glands: Found in the underarms, groin, and perineum; they secrete odorless, lipid-rich fluid. When broken down by skin bacteria like *Corynebacterium*, it produces volatile fatty acids and thioalcohols (odor-causing compounds).
- b. Eccrine glands: Aid in thermoregulation. Their sweat fosters bacterial growth, which may exacerbate odor.

2. Skin Microbiota

- a. Dominated by *Staphylococcus* and *Corynebacterium* species, the axillary microbiome is key in odor production. Imbalances can intensify malodor.

3. Systemic Factors

- a. Diet: Garlic, onions, alcohol can lead to malodorous sweat.
- b. Medical conditions: Liver/kidney dysfunction, uncontrolled diabetes, trimethylaminuria, certain medications (e.g., antidepressants) may cause or worsen odor.²

Clinical Approach

- Start with Empathy and Privacy
- Create a safe space: Discuss body odor in a private, nonjudgmental setting to reduce patient embarrassment.
- Normalize the concern: Frame it as a physiological issue rather than a personal failing.
- Ask open-ended questions: "Have you noticed any persistent odor or changes in sweat patterns recently?"

Differential Diagnoses and Work-Up

Rule out conditions like intertrigo, worsened by secondary bacterial or fungal infections, erythrasma (*Corynebacterium*, coral-red under Wood's lamp), and metabolic disorders (e.g., trimethylaminuria). For persistent cases, use diagnostic tools such as Wood's lamp, urinary trimethylamine testing, and laboratory work-up (liver, kidney, diabetes screening).

Hygiene Practices (First-Line)

- Antibacterial soaps: Recommend daily washing with antibacterial soaps containing benzalkonium chloride, or chlorhexidine gluconate 4% or benzoyl peroxide 5% wash, focusing on odor-prone areas such as the underarms, feet, and groin to minimize bacterial colonization.
- Exfoliation: Advise gentle exfoliation 2–3 times a week with a loofah or scrub to reduce biofilm formation on the skin.
- Hair removal: Shaving, epilation, or laser to reduce bacterial retention.
- Clothing: Breathable fabrics (cotton, moisture-wicking), antimicrobial textiles (silver-infused), frequent changes, proper laundering.
- Drying: Pat skin dry after bathing, especially in high-sweat areas, to limit bacterial growth.

Product Selection

Explain the difference between deodorants and antiperspirants deodorants neutralize odor, whereas antiperspirants decrease sweat production.

For more effective control, consider clinical-strength antiperspirants or formulas containing aluminum chloride.

Diet Modifications

Suggest keeping a food diary to identify triggers and cutting back on strong-smelling foods if needed.
(3)

Medical Interventions

Topical Medications: Targeting the Source

Topical agents play a critical role in controlling bromhidrosis by reducing sweat production and bacterial activity. (Refer to table 1)

Table 1

Drug / Procedure	Concentration / Dosage	Mechanism of Action	Duration of Effect	Frequency	Side Effects
Glycopyrronium tosylate wipes	2.4% topical wipes	Anticholinergic: blocks muscarinic receptors, reducing sweat gland activation	~24 hours	Once daily	Dry mouth, erythema, skin irritation, burning/stinging
Glycopyrronium bromide cream	2% cream	Blocks acetylcholine signaling at sweat glands	Weeks	Once nightly for up to 12 weeks	Burning, stinging, possible dry mouth
Aluminum chloride hexahydrate	10–20% solution	Causes mechanical obstruction and gland atrophy	Several days to weeks	Daily or nightly until control, then maintenance	Skin irritation, itching, burning, contact dermatitis
Zinc ricinoleate / enzyme deodorants	As available in OTC products	Binds odor compounds and breaks them enzymatically	Temporary	As needed	Mild irritation (rare)
Benzoyl Peroxide	2.5–10% cream/gel, 5% wash	Releases free radical oxygen that oxidizes bacterial proteins, kills Cutibacterium acnes	Variable (days–weeks)	Once or twice daily	Dryness, peeling, erythema, irritation
Chlorhexidine	2–4% solution or wipes	Broad-spectrum antiseptic; disrupts microbial cell membranes	Temporary (hours)	Twice daily or as prescribed	Skin irritation, dryness, rare allergic reactions
Topical Antibiotics (Clindamycin, Erythromycin)	Clindamycin 1%, Erythromycin 2% gel/solution	Inhibits bacterial protein synthesis, reduces bacterial load	Variable (days–weeks)	Once or twice daily	Dryness, irritation, antibiotic resistance risk

Systemic Treatments: Beyond Topicals

For patients with moderate to severe bromhidrosis or those unresponsive to topical therapies, systemic options may be considered.

Oral Anticholinergics

1. **Glycopyrrolate:** Initiate treatment at 1 mg once daily, with gradual titration up to 2–4 mg per day based on tolerance and response.
 - a. Mechanism: Reduces sweat production by blocking muscarinic receptors in sweat glands.
 - b. Side Effects: Common adverse effects include dry mouth, urinary retention, and blurred vision, requiring close monitoring.
2. **Oxybutynin:** Start with 2.5 mg once daily; titrate up to 5–10 mg/day. Contraindicated in glaucoma and urinary retention. Side effects include dry mouth and blurred vision.

Systemic Antibiotics

Short courses of oral antibiotics, such as doxycycline 100 mg once daily, may be prescribed to manage secondary bacterial infections in resistant cases. Limit treatment to 4–6 weeks to prevent resistance.⁽⁵⁾

Procedural Options: When Topicals Aren't Enough

For patients who do not achieve satisfactory results with medications, procedural interventions offer effective alternatives.

Botulinum Toxin A

Dosage: Typically, 50 units per axilla are injected intradermally.

How It Works: It inhibits the release of acetylcholine, a neurotransmitter that triggers sweat secretion from the sweat glands.

Duration: Effects last between 4 to 6 months, with most patients reporting high satisfaction and improved quality of life.⁽²⁾

Laser Treatments

Nd:YAG Laser, CO₂ laser, Semiconductor laser: Targets and coagulates apocrine sweat glands, decreasing sweat output. Clinical studies report around 75% patient satisfaction at 6 months post-treatment.⁽⁶⁾⁽⁷⁾

Microneedling fractional radiofrequency, High-frequency electroacupuncture and β -particle bromhidrosis treatment device are also effective options.⁽⁸⁾

Microwave Thermolysis

This technique uses microwave energy to selectively destroy sweat glands. Patients often see a marked reduction in sweating and odor after just 1 or 2 sessions.⁽⁹⁾

Surgical Approaches

Suction-Curettage: Minimally invasive removal of apocrine glands by suction and curettage, suitable for moderate cases.

Local skin Excision, Radical resection with small incision: Reserved for severe, refractory bromhidrosis due to the higher risk of scarring and longer recovery time.

Endoscopic-assisted bromhidrosis treatment and follicular unit extraction technology application are other surgical methods that have tried and tested with good results.

Thoracic sympathectomy, which entails severing sympathetic nerves to reduce sweat production, may be considered as a final option.⁽¹⁾

Special Populations

Pediatric: Avoid systemic anticholinergics, advise daily washing with 4% chlorhexidine and applying low-dose (10%) aluminum chloride topically at night, no more than twice weekly.

Pregnancy/Lactation: Use benzoyl peroxide $\leq 5\%$ and chlorhexidine only; systemic anticholinergics and botulinum toxin are contraindicated.

Elderly: Use systemic glycopyrrolate at low dose (1 mg/day); monitor for anticholinergic side effects, including dry mouth, urinary retention, cognitive impairment.

Practical Pearls for Clinical Success

- **Individualized Care:** Tailor treatments based on the patient's specific needs and response to therapy.
- **Combination Strategies:** Use a mix of hygiene measures, topical agents, and systemic therapies for better outcomes. (Refer Table 2 for treatment algorithm)
- **Patient Education:** Discuss realistic expectations and emphasize adherence to regimens.
- **Follow-Up and Maintenance:**
 - Schedule follow-ups every 3–6 months to monitor progress and adjust treatments. Emphasize maintenance therapies, like topical antiperspirants and hygiene practices, to sustain results and prevent relapses.

Table 2: Treatment algorithm

Step	Treatment Level	Therapies / Actions	Notes
1	Basic Hygiene & Lifestyle	Regular bathing and cleansing- Use moisture-wicking clothing- Avoid triggers (heat, spicy food, stress)	Foundation for all patients
2	Topical Therapies	Aluminum chloride hexahydrate (10–20%)- Glycopyrronium tosylate wipes (2.4%)- Benzoyl peroxide, Chlorhexidine, Topical antibiotics	First-line medical treatment
3	Systemic Therapies	Oral Glycopyrrolate (1–2 mg)- Oral Oxybutynin (2.5–5 mg)	Use when topical treatments fail or are inadequate; monitor side effects
4	Procedural Therapies	Botulinum toxin type A injections (50–100 units per axilla)- Microwave thermolysis (miraDry)- Iontophoresis	For moderate to severe localized hyperhidrosis
5	Surgical Therapies	Surgical curettage, Radical excision, Sympathectomy (surgical removal/clamping of sympathetic nerves)	Reserved for severe refractory cases; consider risk of compensatory sweating

How to Address the Topic Without Embarrassment

- **Place the focus on biology:** Framing the discussion as “The natural bacteria on our skin sometimes break down sweat in ways that create an odor,” shifts the focus from personal habits to biology.
- **Provide written instructions:** This helps patients process advice without feeling judged during the visit.
- **Empower and reassure:** Let them know that with small adjustments, most cases improve significantly.
- Provide a patient-friendly “odor kit” with sample products like antibacterial soap and clinical antiperspirant.
- An educational, concise handout on effective techniques helps patients implement changes confidently.

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Rosacea Flares: Everyday triggers that patients miss

Dr. Nishi Yadav, UAE

Introduction

Rosacea is a chronic skin condition that flares up in response to various triggers –some obvious, others subtle and often overlooked in daily life. Environmental, physical, emotional, and hormonal factors contribute to flares by inducing skin inflammation, vasodilation, and disruption of the skin barrier. A well-established link exists between rosacea flares and gut-skin health. Helping patients identify and manage daily triggers is essential for reducing flare-ups and improving quality of life.

Common triggers and their management

1. Temperature Extremes

- Hot showers/baths
- Saunas/steam rooms
- Cold windy weather

Management

- Use lukewarm water; limit time in shower.
- Use scarves and protective balms in cold weather.
- Avoid saunas.

2. Sun Exposure

- Even short exposure during commuting or lunch breaks, Dropping and fetching children from school can trigger rosacea by releasing pro-inflammatory cytokines.

Management

- Use broad spectrum SPF 30+ daily, even on cloudy days.
- Use mineral sunscreens like zinc oxide
- Wear hats or seek shade.

3. Food & Beverages

- Hot beverages (tea, coffee, soup) stimulate vasodilation by sympathetic effect.
- Spicy foods, capsaicin, red pepper stimulate receptor TRPV1 causing flushing and stinging.
- Alcohol, especially red and white wine induce inflammation by releasing substance P and calcitonin related peptides.
- Histamine-rich foods (aged cheese, fermented foods), cinnamaldehyde containing food like tomatoes, citrus fruits and chocolates activates Transient receptor potential ankyrin receptor-1 (TRPA1) found in sensory nerves in dermis causing vasodilation.
- Niacin found in tuna, salmon, peanuts, chicken breast causes flushing by acting on niacin G coupled protein receptors found in Langerhans cells via release of prostaglandins around capillaries
- Vitamin B complex, riboflavin deficiency aggravates rosacea symptoms

Management

- Let hot drinks cool.
- Reduce spice level;
- Keep a food diary to identify triggers.
- Limit or avoid alcohol and histamine-heavy foods.
- If patient is following a particular diet like vegan, explain common salads, veggies which can cause flare.

4. Skin Care Products

- Fragranced or alcohol-based products cause irritation, disturbance of skin barrier and pro-inflammatory cytokines release
- Over-exfoliation makes skin very dry and dehydrated
- Harsh cleansers or anti-aging products

Management

- Use gentle, fragrance-free, non-comedogenic products.
- Avoid physical exfoliants and aggressive actives like retinoids Avoid heavy make up and oil-based products

5. Emotional Stress

- Anxiety, embarrassment, or high-pressure workdays and anger trigger rosacea by Activation of the Hypothalamic–Pituitary–Adrenal (HPA) Axis and release of neuropeptides like substance P

Management

- Practice stress reduction: mindfulness, deep breathing, regular exercise, yoga.
- Consider cognitive behavioral therapy (CBT) or counseling for chronic stress.

6. Medications

- Vasodilators (e.g., for high blood pressure nitrates and calcium channel blockers)
- Topical steroids (may worsen rosacea long-term)
- Photosensitizing agents like doxycycline
- Amiodarone and interferon

Management

- Take a detailed history of medications on first visit
- Educate to avoid self-medicating with topical steroids
- List of common medications triggering rosacea can be handed over to the patient

7. Exercise

- Exercise causes increased vasomotor activity, sympathetic nervous system stimulation and increased core temperature.

Management

- Patient is advised to work out in a cool environment and to use cooling towels or fans.
- Hydration and taking breaks to cool down is recommended

8. Hormonal Changes

- Hormonal changes can significantly affect rosacea, especially in women, and are often linked to fluctuations in estrogen, progesterone, and androgens.
- These hormones influence vascular reactivity, inflammation, skin barrier function, and sebaceous gland activity all of which play a role in rosacea.
- Hormonal changes often amplify emotional stress, especially during PMS, menopause, postpartum

Management

- Patient is advised to track flare-ups around hormonal cycles and educated about hormonal management strategies if needed.
- Cross consultations with gynecologist, endocrinologist and psychiatrist are advised if necessary.

9. Gut health

- Proton pump inhibitors and histamine 2 receptor antagonists are widely used for acid suppression in an array of gastrointestinal diseases and the long-term use of the same has been associated with dysbiosis which is a risk factor for rosacea.
- Several reports have substantiated the relationship between H. pylori and rosacea.
- H pylori, small intestine bacterial overgrowth (SIBO), and IBD have been associated with this disease
- H pylori disrupt the gut flora, and increases nitric oxide levels resulting in inflammation, and the clinical picture of rosacea
- IL-8 and TNF- α levels are also increased, leading to more inflammation.

Management

- Restore normal gut flora by introducing high fibre, low carbohydrate and fat diet,
- Add oral probiotics.
- Application of creams containing probiotics to restore the skin pH and increase skin ceramide levels and microbial skin population.
- Avoid prolonged use of proton pump inhibitors

10. Demodex

- Demodex mites are part of normal skin flora but may trigger rosacea when they proliferate excessively or penetrate deeper into the dermis, leading to inflammation.

Management

- Topical treatments:
 - Metronidazole (gel or cream)
 - Ivermectin 1% cream
 - Permethrin 5% (in resistant cases)
- Oral treatments (for moderate to severe cases):
 - Oral ivermectin (single or repeated dose protocol)
 - Oral metronidazole or tetracyclines (e.g., doxycycline)
- Anti-inflammatory support:
 - Short-term use of topical mild corticosteroids (with caution)
 - Oral antihistamines for associated pruritus or inflammation

11. Steroid induced

- Topical steroids, first introduced in 1951, have become widely used, but their uncontrolled or prolonged use can lead to steroid induced rosacea
- Chronic use results in rebound vasodilation, pro-inflammatory cytokine release, epidermal atrophy, dermal degeneration, and collagen breakdown.
- Clinically, it presents as flaming red, scaly skin with papules, especially over the centropacial, perioral, and periocular areas.

Management

- Gradual tapering and withdrawal of the offending topical steroid
- Anti-inflammatory support with:
 - Oral antibiotics (e.g., doxycycline, metronidazole)
 - Short-term antihistamines (for associated symptoms)
- Topical non-steroidal immunomodulators:
 - Tacrolimus 0.03–0.1% ointment (long-term maintenance)
 - Pimecrolimus 1% cream as an alternative
- Supportive care:
 - Gentle, fragrance-free moisturizer
 - Broad-spectrum sunscreen (SPF 30+)
 - Avoidance of other irritants or active ingredients during flare phase

Overall Management of Rosacea

Patient Management Tips

- **Educate:** Emphasize that rosacea is a chronic but manageable condition with appropriate care and trigger avoidance.
- **Trigger Diary:** Encourage patients to maintain a daily log of food intake, activities, skincare products, and symptoms to identify personal triggers.
- **Simple Skincare Routine:** Recommend a gentle, consistent regimen using non-irritating, fragrance-free, and non-comedogenic products.
- **Medical Treatment:** Depending on the phenotype and severity, prescribe appropriate therapy, such as:

1. Topicals: Metronidazole, azelaic acid, ivermectin, brimonidine

2. Oral medications: Doxycycline (low-dose), minocycline

Low-Dose Isotretinoin in Rosacea

- **Efficacy:** Low-dose isotretinoin has shown significant effectiveness in treating inflammatory rosacea and in reducing relapses.

- **Dosing:**

- As low as 5 mg daily or 40 mg once weekly has been effective, especially in moderate to severe or treatment-resistant cases.
- These regimens minimize typical isotretinoin side effects while maintaining efficacy.

- **Mechanism of Action:**

- Reduces sebaceous gland size and sebum production
- Decreases follicular hyperkeratinization
- Exhibits anti-inflammatory, immunomodulatory, and antibacterial properties

Considerations:

- Best for phymatous or papulopustular subtypes
- Requires close monitoring, especially in women of childbearing age due to teratogenic risk
- Can be used off-label under specialist supervision

3. Procedures: Laser therapy for persistent erythema or telangiectasia

- Follow-Up: Schedule regular reviews to reassess treatment efficacy, side effects, and newly discovered triggers.

Recommended Reading

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Rosacea or Seborrheic Dermatitis? My Clinical Clues to Tell Them Apart Fast

Dr. Pooja Bains, Amritsar

Rosacea and Seborrheic dermatitis are chronic inflammatory conditions that share various clinical manifestations, so a meticulous approach is required to distinguish them accurately. Research has demonstrated that individuals with Seborrheic dermatitis often experience comorbidity with rosacea and steroid-induced rosacea.¹ Before we investigate the clinical features that differentiate these two conditions, it is prudent to refresh our foundational knowledge of these two entities.

Lets recap our textbook knowledge

Rosacea

- Rosacea is a chronic inflammatory disease which presents as transient to persistent facial erythema, telangiectasia, papules, pustules, oedema, or a combination of these.²
- It predominantly affects the centrafacial areas, mainly the chin, nose, cheeks, and forehead.
- It is more common in women predominantly between 30 and 50 years of age
- There is burning or stinging sensation, but rarely pruritus.

Seborrheic Dermatitis

- Seborrheic dermatitis is a chronic inflammatory condition characterized by pruritic erythematous scaly papules and patches.³
- It involves seborrheic areas including scalp, face, chest, and back, sometimes affecting the genitals, gluteal cleft, and groins.
- The adult form of Seborrheic dermatitis affect men more than women with a variable course throughout adulthood.³
- There is accentuation at nasolabial folds, retroauricular area, eyebrows, scalp where scaling is predominant.
- It is associated with pruritus

Lets look at the practical aspect of how to tell the two conditions apart clinically

My clinical clues lies in : history taking, cutaneous examination.

- **History taking:** Asking about the symptoms and course of the disease : age of onset and initial areas of involvement, presence of burning sensation and or itching,flushing, drug history, triggering factors,seasonal variation,history of topical application if any.
- **Examination**
 - Sites : A thorough examination of the face, scalp, other seborrheic areas. This will help ascertain the sites of involvement ,if any, other then the face.
 - Morphology of lesions: look out for papules, pustules, background telangiectasia, erythema, scaling.

Clinical Clues

1. Site matters: Where Do You See It?

Rosacea

- Central face: Cheeks, nose, chin, and forehead.
- Rarely extends beyond the face.

Seborrheic Dermatitis

- Scalp, eyebrows, glabella, nasolabial folds, ears, and chest.
- Often involves the scalp and retroauricular areas.

2. Texture and Appearance: Touch and Look Closely

Rosacea

- Persistent erythema with telangiectasia
- Papules/pustules but no comedones

Seborrheic Dermatitis

- Greasy, yellow-white scales- predominant
- Telangiectasia: less prominent

3. Symptoms: What Does the Patient Feel?

Rosacea

- Stinging/burning
- Flushing: Triggered by extremes of temperature, alcohol, spicy foods, sunlight or emotional stress.
- Rarely itchy.

Seborrheic Dermatitis:

- Itching present
- Burning: Possible but less intense than rosacea.
- No flushing.
- Aggravation by: Emotional stress, anxiety ,depression, humidity and trauma

Quick-Reference Table

Feature	Rosacea	Seborrheic Dermatitis
<i>Location</i>	Central face (cheeks, nose)	Scalp, eyebrows, nasolabial folds
<i>Texture</i>	Smooth, background, erythema, papules, pustules, telangiectasia	Greasy, scaly patches
<i>Symptoms</i>	Stinging, flushing	Itchiness, scaling
<i>Triggers</i>	Heat, alcohol, stress	Stress, humid weather, anxiety, depression

Still in Doubt-----Dermoscopy to our Aid

Dermoscopic Feature	Rosacea	Seborrheic Dermatitis
<i>Morphology of Vessels</i>	Linear vessels arranged in polygonal networks	Dotted or curved vessels in patchy distribution. ^{4,5}
<i>Scales</i>	White	Yellow
<i>Background colour</i>	Dark red	Pink

Pearls

- Some patients don't appreciate flushing due to dark skin, so specifically asking about a feeling of warmth with triggers should be inquired.
- Never miss retro auricular areas in examination
- If the scalp is scaly and itchy, think seborrheic dermatitis first. If redness is confined to the central face with visible vessels, lean toward rosacea.

Final Thoughts

Understanding these nuanced differences between Rosacea and Seborrheic dermatitis can improve treatment outcomes and enhance patient care, particularly in cases of overlapping symptoms. We emphasize the importance of clues like site identification, morphological characteristics, and patient symptoms along with valuable role of Dermoscopy in clinching an accurate diagnosis.

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A. Updated Treatment for Acne: Targeted Therapy Based on Pathogenesis. Kurokawa I, Layton AM, Ogawa R. Dermatol Ther (Heidelb) (2021) 11:1129–1139

In this review authors try to give analysis of the evolving understanding of acne pathogenesis and its implications for treatment strategies. The article suggested the importance of targeting specific pathophysiological mechanisms to enhance treatment efficacy and minimize side effects. The article highlights the shift towards personalized medicine in acne treatment, suggesting therapies that target specific pathogenic mechanisms. While conventional treatments remain present and effective, the addition of biologics and a deeper understanding of the microbiome and immune pathways advocates promising future for managing severe acne and preventing scarring

Key Point

1. In this review authors have pointed out potential novel approaches in acne treatment targeting immunology and wound healing, as there is better understanding of pathophysiology and immunological aspect.
2. Biological antibodies targeting IL1b, IL-17, IL-23, & TNFa may be helpful to manage severe acne in future
3. Biological antibodies targeting TGFa, IL-6, MMP, IGF-1 may be helpful in preventing and managing scars in future.
4. Treatment should be aimed to treat acne and its sequelae, focusing to take care of main etiological factors of acne.

B. Avraham S, Khaslavsky S, Kashetsky N, et al. Treatment of ocular rosacea: a systematic review. JDDG: Journal der Deutschen Dermatologischen Gesellschaft. 2024; 22:167–174. <https://doi.org/10.1111/ddg.15290>

This review article gives a comprehensive analysis of various treatment modalities available for ocular rosacea. The study included 66 articles involving 1,275 patients and assessed the efficacy and adverse events associated with different treatments modalities.

Key Points

1. The review highlights the individualized treatment plans for ocular rosacea, due to varying efficacy of different therapies.
2. Topical antimicrobials and oral antibiotics are recommended as first-line treatments, as they were found to be most effective
3. IPL and cyclosporine ophthalmic emulsion are also available options, mainly when combined with other therapies.
4. Lid hygiene remains a supportive measure but should not be relied upon as the sole treatment.
5. When modalities are used in combination, treatments achieved a 90% response rate, underscoring the benefit of a multifaceted approach
6. Dermatologist perspective: Its wiser to refer to ophthalmologist and discuss the treatment.

C. Samifanni R, Gatt V, Kabore J, et al. Effectiveness of Anti-tumor Necrosis Factor Drugs on Hidradenitis Suppurativa: A Systematic Review. Cureus 2024;16(11): e74172. DOI 10.7759/cureus.74172

HS is a chronic inflammatory skin condition characterized by painful nodules, abscesses, and scarring, often leading to significant patient distress and reduced quality of life. This review article got published in Cureus in November 2024, which evaluates the efficacy of anti-TNF therapies mainly adalimumab and etanercept in treating hidradenitis suppurativa (HS).

Key Points

1. Anti-TNF therapies, especially adalimumab, promising treatment option in the management of moderate-to-severe HS.
2. The review highlights there is a potential future of newer biologic agents targeting interleukin-17 (IL-17), such as secukinumab. These therapies may offer alternative options for patients who do not respond adequately to anti-TNF treatments.
3. There need for personalized treatment approaches Treating doctor always need to consider individual patient responses and potential side effects when selecting appropriate therapies for HS

D. Stamatiou Gregoriou, Polytimi Sidiropoulou, Georgios Kontochristopoulos & Dimitrios Rigopoulos. Management Strategies of Palmar Hyperhidrosis: challenges and Solutions. Clinical, Cosmetic and Investigational Dermatology 2019;12 733–744.

The management of 'Palmar hyperhidrosis' is real clinical challenges due to its impact on quality of life and the variety of available treatment options, with difficult to get desired satisfactory outcome. This article emphasize that an individualized treatment approach is essential, balancing efficacy, side effects, and patient preferences.

Key Points

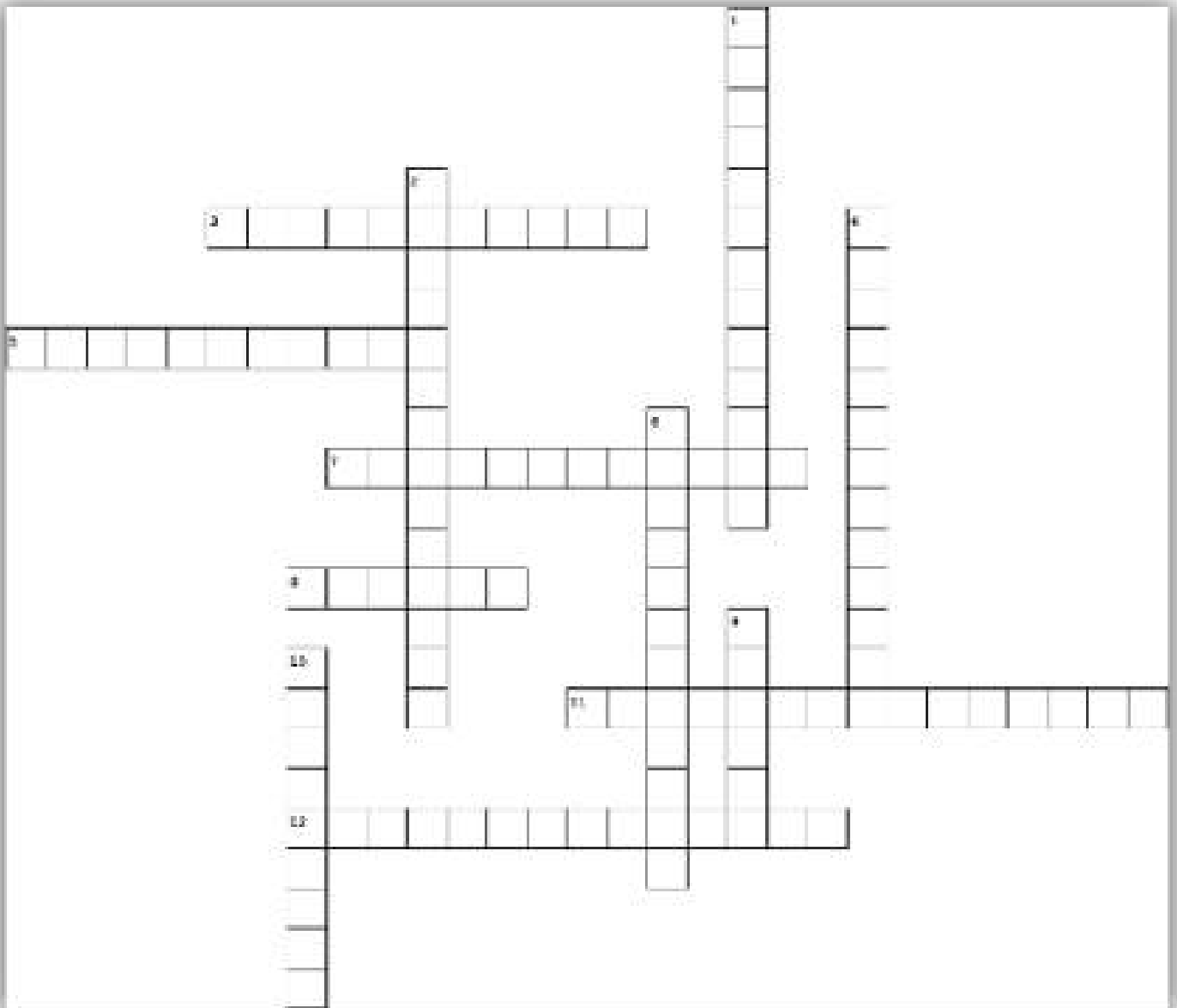
1. Despite a wide range of available treatments ranging from topical therapies and iontophoresis to botulinum toxin injections and surgical interventions no single approach is universally effective.
2. Non-invasive methods should be tried first like topical agents (aluminum chloride with limited efficacy), 'Iontophoresis' is also effective option for few patients. Botulinum toxin injections offer a potent solution, but lots discomfort and the need for repeat treatments; most patient do not take.
3. Continuous advancements in understanding and managing this condition are essential for improving patient outcomes.

Acne and Appendageal Disorder – Crossword Quiz

Dr. Nidhi Shah, Mumbai

Instructions to Solve the Crossword

- Read each clue carefully and fill in the correct answer.
- Ensure spelling accuracy and check for correct letter alignment.
- Two-letter words, if present, should be considered with a space/hyphen in the grid.



Across

3

Biologic therapy approved by the FDA in 2025 for moderate to severe hidradenitis suppurativa.

5

Rare benign sweat gland tumor with eccrine or apocrine origin.

7

First-in-class topical therapy targeting hormonal influence in acne pathogenesis

8

A novel mutation in which gene has been linked to a combined phenotype of Dowling-Degos disease and hidradenitis suppurativa, suggesting a pivotal role in Notch signaling within follicular structures

11

Common topical agent exacerbating acne.

12

Acne variant with systemic symptoms and ulcerations.

Down

1

Neurotransmitter stimulating eccrine sweat glands.

2

Prickly heat rash caused by sweat duct obstruction.

4

AMP family contributing to innate immunity and dysregulated in acne

6

Malodorous sweat disorder linked to bacterial metabolism.

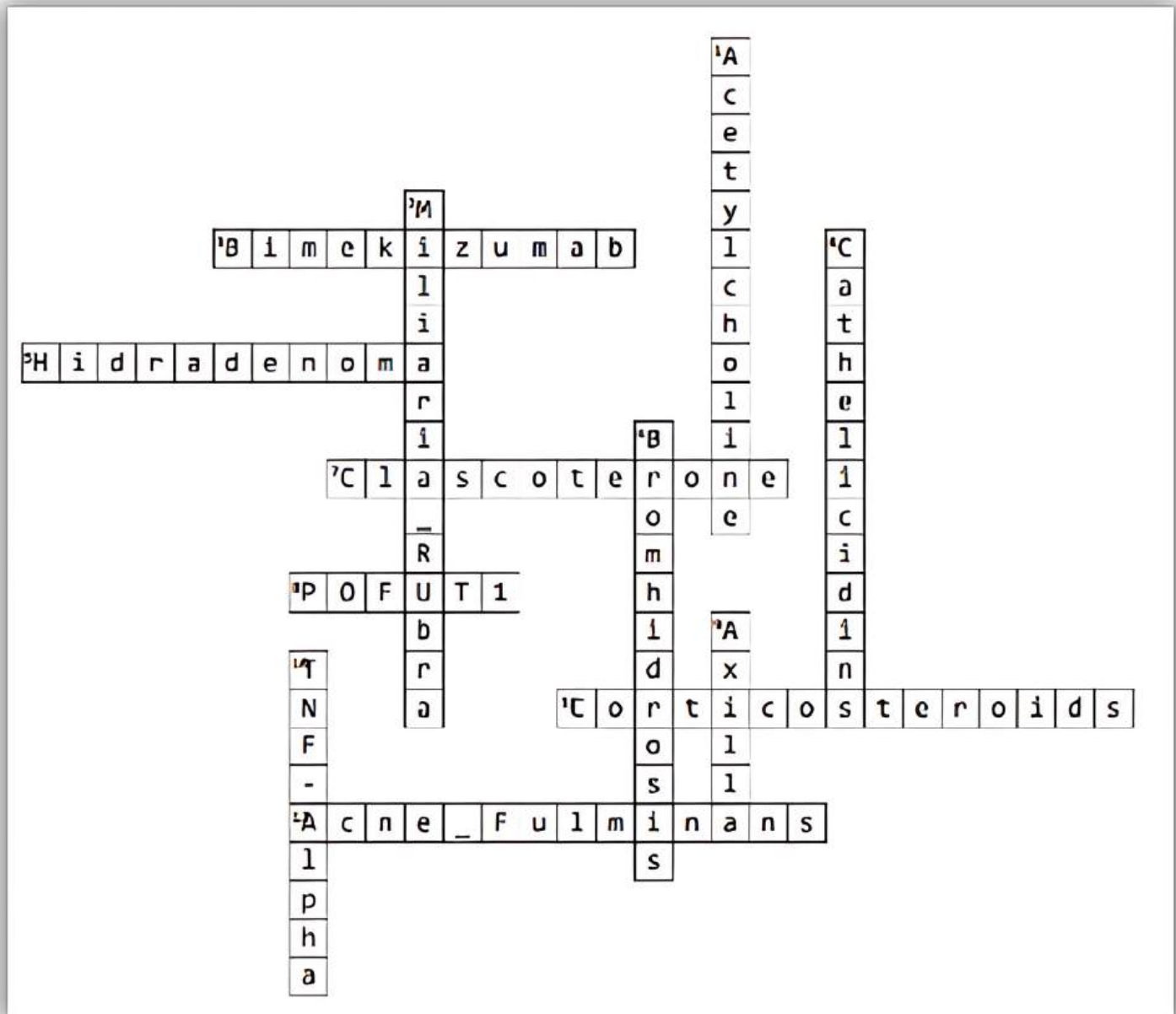
9

Primary site of Fox-Fordyce disease involvement.

10

Key inflammatory mediator driving HS progression.

Answers



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