

Indian Association of Dermatologists, Venereologists & Leprologists West Bengal State Branch



SKINTELLECT

The Official Newsletter of the IADVL West Bengal State Branch

Issue Spotlight

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"Skintellect," is the online monthly newsletter of the IADVL WB, dedicated to the dynamic world of dermatology. This publication is a testament to the commitment of our members towards advancing the ever stretching horizon of the discipline, sharing knowledge, creating bonhomie and archiving our IADVL WB activities.

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Note from the President

Dear Members,

October has been an eventful and fulfilling month for all of us in IADVL–West Bengal. Our flagship annual conference, CUTICON-WB, was conducted successfully, and it gives me immense pleasure to extend my heartfelt appreciation to everyone who made this possible.

My deepest gratitude to our Organizing Secretary, Dr. Subhomoy Neogy, and his dedicated team for their exemplary efforts in planning and executing this conference with such precision and efficiency. I also extend sincere thanks to our Scientific Chairperson, Dr. Sudip Ghosh, and Scientific Secretary, Dr. Partha Mukherjee, for meticulously curating a rich scientific programme that was appreciated by delegates across all levels.

A special acknowledgement is due to our Honorary Secretary, Dr. Suchibrata Das, for his seamless coordination and oversight, and to our Treasurer, Dr. Indrasish Podder, for his consistent support throughout.

The Pre-conference Dermatopathology Workshop, organized by Dr. Kisalay Ghosh as well as the Dermatosurgery Workshop conducted by Dr. Aniruddha Ghosh, were highly impactful and added great academic value to CUTICON-WB. We are grateful to our esteemed guest faculty from across the country, as well as all speakers, chairpersons, and panelists for their valuable contributions. The tireless efforts of our volunteers deserve special mention—they were the backbone of this event.

As we move into December, we look forward to hosting several interesting academic activities that will continue to strengthen the scientific spirit of our fraternity.

Warm regards,



Dr. Dinesh Kr. Hawelia
President
IADVL WB

Secretary's Scribes

Dear Members,

Welcome to this edition of SKINTELLECT. We are still filled with the spirit of CUTICON-WB 2025, which concluded with heartfelt appreciation for its scientific excellence, smooth organization, warm hospitality, and outstanding venue. These accolades truly belong to every member of the team who worked tirelessly behind the scenes.

My sincere gratitude to our President, Dr. Dinesh Hawelia, whose steady guidance—like the head of a united family—supported us even in the most challenging moments. My heartfelt thanks to Dr. Subhomoy Neogi, our Organizing Secretary, for his exceptional leadership; and to our Scientific Chairperson Dr. Sudip Ghosh and Scientific Secretary Dr. Partha Mukherjee, for designing such a rich and memorable academic programme.

We are deeply grateful to all our esteemed speakers, and especially to Dr. Kisalay Ghosh and Dr. Aniruddha Ghosh for their outstanding workshops. Special appreciation goes to our Treasurer, Dr. Indrasish Podder, for his efficient and transparent financial management, and to our enthusiastic young volunteers whose energy strengthened the event.

Our dedicated office staff—Mr. Khageshwar, Mr. Prasenjit, and Mr. Tapas Kayal—deserve warm thanks, along with Mr. Samar Babu for the excellent décor and catering.

The scientific sessions were illuminated by the presence of eminent national and state faculties, whose erudition elevated CUTICON-WB 2025 to another level. Our heartfelt thanks to each of you. To all the delegates, thank you for your participation and support—this event was organized for you, and your wholehearted involvement made it truly successful.

As always, IADVL WB continues its forward journey. Our Dermatology–Rheumatology Conference on 5th December at Hotel Park promises yet another enriching academic experience.



Dr. Suchibrata Das
Honorary Secretary
IADVL WB



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Editors Desk

Dear Readers,

November has been truly special with the remarkable success of Cuticon WB 2025—an event brimming with enthusiasm, academic exchange, and camaraderie. The conference was graced by eminent dermatologists from within the state and beyond, and the organisers deserve special appreciation for the seamless execution of such a meticulously curated programme.

This month, Dr. Alok Kr Roy shares his inspiring journey in the field of dermatology.

In the Dermbuzz section, Dr. Sk. Shahriar Ahmed explores the possibilities of a curative treatment approach for psoriasis—long regarded as an incurable condition.

In the Residents' Corner, Dr. Parthasarathi Ghosh highlights the evolving and exciting applications of biotechnology in dermatology.

The Dermaginations section brings you another delightful story by Dr. Arijit Coondoo, along with a captivating photograph by Dr. Kingshuk Chatterjee.

As the winter chill sets in, don't forget to refresh your mind with this month's dose of Brainstorm.

Happy Reading!



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DERMATOLOGIST SPOTLIGHT: DR. ALOK KR. ROY



- Q1.** *Dermatology has evolved tremendously over the decades. What are some of the biggest changes you've witnessed in the way skin diseases are diagnosed or treated since you began your practice?*
- A:** *Absolutely. Over my four-decade-long association with dermatology, I have witnessed transformative changes. In the early years, there were very few dermatologists, mostly concentrated in big cities, and resources were limited. They were exceptional clinicians but had to rely heavily on histopathology. There was no immunofluorescence, no immunocytology, no genetic mapping, and no dermatoscope. One may wonder how they worked so brilliantly—but of course, their numbers were very small.*
- Q2.** *You've mentored countless young dermatologists. What qualities distinguish a good dermatologist from a great one?*
- A:** *I see many young dermatologists today ready to carry the torch forward. Over the decades, their numbers and calibre have grown tremendously. Some are already great, and many have the potential to reach that stature. To become great, one must go beyond strong clinical skills and deep subject knowledge. A great dermatologist is sincerely involved with the subject, makes thoughtful use of available resources, and develops the ability to interpret situations accurately. Great dermatologists are, in a way, born when they love the subject—mentors certainly help, but one finds the right mentor only when one genuinely seeks one.*
- Q3.** *In the race between clinical dermatology and aesthetic dermatology, where should the balance lie?*
- A:** *Is there really a difference? Every good dermatologist has an inherent aesthetic sense—without it, one cannot become great. While it's true that increasing numbers will choose to practice only aesthetics, they must first be strong clinicians. Otherwise, they risk becoming beauticians rather than true cosmetologists.*
- Q4.** *Many skin conditions today have a psychosomatic component. How do you approach the emotional or psychological aspects of dermatological care?*
- A:** *Certainly. Besides well-known clinical situations that require psychiatric referral, many chronic skin conditions carry a psychosomatic element that can be challenging. I'm not sure how many busy dermatologists feel satisfied with how they handle this aspect. A team-based approach can be immensely helpful. This is usually possible in larger hospitals where multispecialty clinics—for psoriasis or vitiligo, for example—can be established.*
- Q5.** *One piece of advice for young dermatologists entering the field in 2025?*
- A:** *You have tremendous opportunities—excellent training centres, inspiring teachers, and advanced tools. When we trained, access to international journals was limited, good textbooks were scarce, and the internet didn't exist. My advice is simple: love the subject and remain sincere. That alone will propel you toward becoming a good dermatologist.*
- Q6.** *What is one dermatological condition that continues to fascinate or challenge you even after years of experience?*
- A:** *Only one? Every patient is an individual, and their problems are unique. Beyond infectious diseases, dermatology is all about management, and each case presents differently. But if I must name a few—psoriasis, eczema, acne vulgaris, and of course, dermatophytosis in recent years.*



Q7. How do you see artificial intelligence influencing the future of dermatology practice in India?

A: AI is already reshaping many aspects of our work, and dermatology is no exception. At present, its role may be limited to administrative or back-end tasks, but soon it will be integrated—though in a limited way—into clinical practice. In dermatosurgery and aesthetic dermatology, however, its applications may be far greater. This is my belief.

Q8. Teledermatology has improved accessibility. What opportunities and challenges have you observed?

A: My experience in the early 2000s was not encouraging—poor-quality images, inadequate history, often relayed by paramedical staff. It felt like a complete waste of time. That was long ago, though, and I'm sure the systems have improved now. Teledermatology is valuable where dermatologists are scarce. But today, dermatologists are available across nearly every corner of our state. Personally, I am not in favour of teleconsultations.

Q9. Looking back, what has been the most rewarding moment of your career?

A: I don't consider myself a great clinician—it is simply a profession I can do well. But yes, there have been gratifying moments. When I joined the field, West Bengal had only four MD seats in dermatology, and this remained unchanged until 2008. The situation was similar across India. I felt strongly that the number of seats needed to increase. When the opportunity came, my colleagues and I modernised our department and secured permission from the MCI to start MD (DVL). Later, I did the same at another medical college. With seven new students each year, I feel I've given something back to the subject that has given me my identity. I hope some of my students will become great one day.

Q10. Outside the clinic, what rejuvenates you? What hobbies or passions keep you inspired?

A: Even at this age, continuing to work is my greatest source of rejuvenation. Beyond that, I enjoy many things. Music gives me immense joy. I love listening to live commentary of cricket and football, and occasionally tennis and badminton. I also enjoy reading books outside the realm of dermatology.

DERMBUZZ : CAN WE FINALLY CURE PSORIASIS?

Dr SK Shahriar Ahmed
Faculty: CNMC

How the Nobel Prize in Medicine This Year Is Changing the Landscape of Autoimmune Disease Treatment

Introduction

Let me ask you this: how many times have you heard from your patients, "Doctor, when will I finally be free of this disease?" We've all heard it. And honestly, for decades, our answer has essentially been, "Never—but we can suppress it indefinitely." But here's the thing—the 2025 Nobel Prize in Physiology or Medicine was awarded for discoveries that are finally changing this answer.

Mary Brunkow, Fred Ramsdell, and Shimon Sakaguchi won the Prize for identifying regulatory T cells (Tregs) and the master gene *FOXP3* that controls them. This isn't abstract immunology—it's revolutionising the treatment of psoriasis, atopic dermatitis, and other autoimmune skin diseases. More importantly, it's revealing why these diseases recur and, critically, how we can actually cure them by moving from generalized immunosuppression to precision cytokine targeting.



The Classical Interplay: Tissue-Resident Memory T Cells (TRM) vs. Regulatory T Cells (Tregs)

Regulatory T Cells, a type of T-helper cell, play a central role in peripheral tolerance by eliminating or suppressing autoreactive T cells and Tissue-Resident Memory T Cells. Thus, they limit chronic inflammation and autoimmune disease. *FOXP3* is the master transcription factor that helps naïve T-cells turn into Tregs. IL-2 and TGF-beta induce this *FOXP3* expression. In psoriasis, Tissue-Resident Memory T Cells (TRM) cells act as localized immune sentinels and persist in previously affected skin over time. These TRM cells produce pro-inflammatory cytokines such as IL-17 and IL-22, which promote keratinocyte hyperproliferation and sustain psoriatic lesions. They are the main cause of relapses. Both the number and function of Tregs are reduced in psoriatic skin, limiting their ability to control harmful TRM cells. The recurrent nature of psoriasis lesions may be explained by a self-perpetuating cycle triggered by immune homeostasis disruption. Focusing on reducing harmful TRM cells while increasing beneficial Tregs could help achieve long-lasting remission or possibly cure psoriasis.

The Fundamental Problem: Why Generalised Immunosuppression Fails

Think about what we've been doing for decades in patients with moderate-to-severe psoriasis. We start methotrexate or cyclosporine. They were the game-changing molecule in the early days of psoriasis treatment and continue to play a significant role, particularly in cases when economic considerations heavily influence the choice of molecule. But these drugs work by non-selectively suppressing all T cells, destroying immune function broadly rather than addressing the specific pathogenic mechanism.

Here's what actually happens: We suppress inflammation temporarily, but the disease flares a few months after we stop. Why? Because they don't target the root problem: persistent tissue-resident memory T cells (TRM) and dysfunctional regulatory T cells (Tregs).

Methotrexate and cyclosporine are blunt instruments. They suppress everything indiscriminately, including the Tregs that should be maintaining immune tolerance. They leave TRM cells—the sleeper agents permanently stationed in the skin—completely untouched and ready to reactivate.

This sometimes results in the disease flaring rapidly upon discontinuation. Some of these patients require indefinite therapy with cumulative toxicity risks—hepatic cirrhosis, renal failure, infections, and malignancies.

The Precision Revolution: IL-17 and IL-23 Inhibitors Target the Disease Mechanism

Contrast this with precision biologic therapy targeting specific pathogenic cytokines. Instead of destroying immunity broadly, these agents block the exact molecules driving disease.

IL-17 inhibitors (secukinumab, ixekizumab) block interleukin-17, the downstream effector cytokine produced by pathogenic Th17 cells. They achieve remarkable efficacy within a short period of time. This precision targeting means we're suppressing the specific inflammatory pathway driving psoriasis, not demolishing global immunity. Yet, they leave one critical problem: IL-17 inhibitors don't eliminate TRM cells; they only suppress their effector functions.

IL-23 inhibitors (guselkumab, risankizumab, tildrakizumab) go further—they block the upstream cytokine maintaining TRM survival. This is the game-changer. Breakthrough skin biopsy studies showed that after 6 months of guselkumab, CD8+ CD103+ TRM cells were actually reduced. Secukinumab or methotrexate at the same time point showed no TRM reduction—the pathogenic cells persisted untouched.

Restoring FOXP3+ Tregs

Generalized immunosuppressants destroy Tregs. To prevent recurrence we need to selectively restore Tregs through FOXP3 targeting.

IL-2 receptor agonists like rezpegaldesleukin (REZPEG) do what no generalized immunosuppressant can:

- *Selectively expand FOXP3+ Tregs: 15.9-fold (CD25-bright subset).*
- *Leave effector T cells unchanged.*
- *Phase 1b trials showed clinical improvement maintained 36 weeks post-treatment through the induction of immune tolerance.*

Hit Early, Hit Hard: The TRM Advantage

Here's a staggering finding from a study of 1,975 psoriasis patients:

- *Disease duration <5 years: 88.9% achieved drug-free remission post-discontinuation.*
- *Disease duration >15 years: Only 18.1% achieved drug-free remission.*

Why? TRM accumulation. Each disease episode deposits more TRM cells. After 15+ years, pathogenic populations are extensive, epigenetically programmed for tissue residency, and maintained by IL-15 signaling. Critical implication: If patients had received IL-23 inhibitor therapy early, instead of starting with methotrexate (which doesn't eliminate TRM), they would have had 80-90% remission rates instead of 18%.

The KNOCKOUT trial tested high-dose IL-23 inhibition (risankizumab 300-600 mg vs. standard 150 mg):

- *Week 52 (9 months post-final dose): 43% maintained PASI-100—the highest sustained remission ever documented.*

The Combination Strategy: Eliminating Generalised Suppression

The combination of 2 precision approaches:

Phase 1 (Weeks 0-16): High-dose IL-23 inhibition.

- *Rapidly depletes TRM populations.*
- *Removes pathogenic immune memory.*
- *Selectivity means normal immunity is preserved.*

Phase 2 (Weeks 16-40): IL-2 receptor agonist addition.

- *Expands FOXP3+ Tregs 15-fold.*
- *Restores immune tolerance via Tregs.*
- *Stabilizes remission through Treg-mediated homeostasis.*



Conclusion

The question isn't whether to use biologics—it's whether we can justify continuing generalized immunosuppression when precision alternatives exist.

Methotrexate and cyclosporine represented progress once. But they are blunt instruments that destroy immunity broadly, eliminate Tregs, leave TRM untouched, and result in higher rates of relapse. IL-23 inhibitors represent genuine disease modification. They eliminate pathogenic TRM, preserve Tregs, achieve remission in most patients, and carry minimal toxicity.

Combined with IL-2 receptor agonists that restore FOXP3+ Tregs, we're transitioning from chronic disease management to an actual cure for meaningful patient subsets.

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RESIDENT'S CORNER: RISE OF BIOTECH IN SKIN CARE

In the 21st century technology surrounds all our lives, and the world is changing in a breathtaking pace, where biotechnology is stepping forward as the propeller that will redesign life itself. As the famous American geneticist George Church said, "The rewards for biotechnology are tremendous – to solve disease, eliminate poverty, age gracefully. It sounds so much cooler than Facebook." This reminds us of the great transformative potential of biotech. The achievements of biotechnology in medical therapeutics and diagnostics form an impressive list, from the discovery of insulin and the development of recombinant vaccines to the use of PCR as a diagnostic tool and the creation of monoclonal antibodies. In the context of dermatology, biotechnology has revolutionised aesthetic skin care to such an extent everyone needs to ponder a little bit about it.

When we talk about biotech in skincare, few questions strike our mind i.e. Does it really need attention? Why do we need something new in skin care practice? How are they making it possible? Is it really the future?

What makes a product long-lasting and easily acceptable in the market? The answer is mainly the safety, efficacy and consistency.

Important Biotechnology Techniques in Skin Care

- **Plant-based recombinant technology:** We all know barley. Barley is genetically modified, and the barley plant grows naturally. The barley cells use their own protein machinery to produce human EGF just as they make their own seed proteins. And the seed serves as the protective membrane for the delicate EGF. No need for animal cells or bacterial cultures; it's purely plant-based. EGFs are widely used as wound-healing gels, skin rejuvenation serums, and post-laser care.
- **Exosome-based therapy:** Exosomes are tiny cell-derived vesicles with diameter ranging from 40 to 160nm, released by cells that act as natural messengers, carrying proteins, lipids, and nucleic acids between tissues. They influence wound healing, pigmentation, inflammation, and even hair growth by modulating key signalling pathways. Exosome-based biomarkers are emerging as valuable aids for diagnosing and monitoring conditions such as psoriasis, melanoma, and autoimmune dermatoses.
- **Fermentation-based technique:** Biotech fermentation techniques turn microbes into mini factories that make skincare actives. Instead of using shark liver, squalene can now be produced through yeast fermentation using sugarcane, resulting in a stable, non-oxidized moisturizer. Like squalene, hyaluronic acid is also made up of genetically modified bacteria, which is usually derived from rooster combs in non-biotech way.
- **Bioidentical collagen:** It is engineered to mimic human collagen exactly, allowing the skin to recognise it naturally and use it for rebuilding firmness and elasticity. Because bioidentical collagen integrates seamlessly with native tissue, it supports smoother texture, faster healing, and better structural support without the risk of foreign-body reactions.
- **PDRN salmon DNA:** PDRN, or Polydeoxyribonucleotide, is a regenerative molecule extracted from purified salmon DNA, known for activating the adenosine A2A receptor, which boosts tissue repair and reduces inflammation. It stimulates fibroblast activity, collagen production, and microcirculation, making it popular in skin rejuvenation, under-eye treatments, and scar remodelling. PDRN has an excellent safety profile due to its high purification level.

Dr. Parthasarathi Ghosh
1st year PGT, BMCH





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● **Probiotic and microbiome science:** Probiotic skincare uses live microbes, lysates, or fermented extracts to strengthen the skin's microbiome the protective ecosystem of good bacteria. These products help balance pH, reduce inflammation, and calm conditions like acne, rosacea, and eczema by supporting beneficial flora.

Amongst all these promising sides as mentioned, we cannot deny the certain grey zones in the ethical harvesting of human stem cells and lack of complete clinical evidence of biotech products in practising evidence-based medicine. Also, the term 'biotech' has been loosely used throughout social media marketing, which dilutes the credibility and confuses consumers. Again these products are not completely free of side effects and allergens, and the high cost can dent the acceptability on large scale in a country like India.

Despite the pitfalls, biotechnology in dermatology continues to prosper and lead the way using AI-driven skin microbiome analysis in personalised skin care.

DERMAGINATIONS: PAGING PASSION BEYOND PRACTICE

DERMA DLITE SERIES PART 3: YANICK

Dr. Arijit Coondoo
Ex President, IADVL WB



There is a latent belief among laymen and non-dermatologists alike that dermatology is a subject which needs the least of skills and knowledge. Until, of course, they themselves start scratching intractably or their patients suffer from some drug reactions.

Life as a dermatologist is not easy because our speciality involves the most visible part of the body. Hence we have patients lurking at every nook and cranny of this world. Relatives, casual friends, minor acquaintances, beauty conscious neighbours – they are all there ready to accost you at the unlikeliest of all places like wedding functions, market places, children's schools and even alumni meets with their wee little itch. Some even start scratchinjd the moment they catch sight of you and start chasing you about till you give at least some advice.

Towards the end of the last century I used to practice dermatology at my home early every morning. Initially I was reluctant to start work that early. But then, being a doctor and a skin specialist at that, I had gained a lot of popularity in my neighbourhood because of necessity rather than love. Hence, many of my friendly neighbours would simply stroll into my house at the start or the end of their morning walk, ostensibly to enquire about my health (making it appear to be the main cause of their visit) and before leaving, would casually roll up their shirt sleeves to consult about some minor rash on their elbow. One elderly gentleman even had the temerity to inform me with a grin that because of him I had gained some therapeutic experience. Unfortunately, my wife did not help matters by offering a cup of coffee to each of these visitors giving them another excuse to impinge on my privacy.

This charade went on for some time before I decided that enough was enough. As a professional, I was not at all enjoying this voluntary service to society which was imposed upon me.

Hence I decided to start a full fledged clinic charging my chamber fees from all and sundry. This unexpected burden on their pockets resulted in a drastic decrease in the number of early morning visitors to my home. But a few genuine and loyal patients did not desert me.

Among these loyalists was a person who was a bureaucrat suffering from Psoriasis. He had to frequently travel abroad but never failed to visit me whenever he was in town. His disease was majorly under control but he was serious about his check-ups. I was amazed by his unflinching faith in me. However, it was this loyalty, which, one day, landed me in a spot of trouble.

One morning after I had completed checking him and writing his prescription, he came up with an unusual request. He was the owner of a German Shepherd, a pedigreed canine which he had bought in Germany. As I discerned from him, this dog belonged to a royal breed and was very precious. Every year he used to win prizes at all the dog shows held anywhere in India. However, for the past few months he had been affected by a skin disease, making him ineligible for competitions. Some of the leading veterinary doctors of the country had been consulted but to no avail. Unfortunately, there are no veterinary dermatologists, the gentleman lamented. Hence, he needed my help.

"But I am not a veterinary doctor. I am not qualified to treat a dog. In fact it would be illegal for me to treat him."

Unfortunately, all my protests fell on deaf ears.

"Sir, please have a look at him. Just once. I am sure you will be able to do something."

He was unrelentingly insistent until finally, I agreed.

But only on one condition did I agree. - the prescription would be in the gentleman's name, not in the dog's name.

He was elated. He requested me to wait for 15 minutes since It would take him that much time to walk the dog from his house to mine.

"Why walk?"

"Because, Sir, he is too large to fit into my Maruti car."

"But then there is another problem. What about the army of street dogs roaming in our locality? They might attack him."

"No sir. Nothing of that sort will occur. Just wait and see what happens."

"And Sir, another request. While my dog is here, please tie up your dog upstairs."

"Why"

"Because she might fall sick from fear if she sees my dog".

At that point I was the proud owner of an Indie, named Veronica (aka Velu) who was the most timid of all dogs ever born. She was so meek that if the doorbell rang she would run immediately to the remotest corner of the house and hide under a table or a bed.

So, I asked my son to tie her upstairs. Unfortunately, he tied her up in the verandah overlooking our main door with disastrous consequences.

About twenty minutes after the gentleman left, I was startled by the combined wailing of all the street dogs in the area. They were all crying in unison, emitting a weird sound, the crescendo rising and falling much like a factory siren. My chamber boy came rushing in "Dada. A tiger is coming in"

And then he entered. "His very body language conveyed a regal air as if he was the master of all he surveyed. His size was stupendous. Alerted by my chamber boy, my wife and children came rushing down to catch a sight of the giant canine. He stood straight gazing out of the window oblivious to all the attention he was receiving. His muscles were taut, his jaws were clenched. He was indeed the Badshah, uncaring about us plebians.

"Now, how can I examine him" I asked his master' "What if he attacks me?"

Don't worry, I'll take care of that." And he called out in a soft voice' "Yanick, friend."

And lo and behold, Yanick's stature changed completely. All the muscles of his body seemed to relax, he looked at me with a friendly eye and his tail started wagging just that wee little bit. After all, he was royal. He could not express happiness by wagging his tail furiously like a commoner.

Emboldened by this sudden change in his attitude I proceeded to examine him. And, to my utter surprise, my canine patient, like his master was also suffering from Psoriasis. Thus the problem of writing another prescription was solved in the oddest of all ways. I simply asked the gentleman to apply the lotions I had prescribed for him.

Yanick and his maser departed soon thereafter, leaving a trail of despair behind.

The moment they emerged from my chamber, the street dogs started wailing again. This time they were so sure, that he would attack them, that they ran helter skelter, tails held aloft like flags. They were probably not sure about his intentions and therefore decided to leave our neighbourhood altogether and run away to safer zones as far away as possible. It was not before a week that they started coming back one by one, fear written clearly in their eyes and after ensuring that the "tiger" was nowhere around they decided to stay back in safe shelters like garages and backyards.

Meanwhile my dog Velu, had seen Yanick from the verandah where she was tied. She had immediately started shivering uncontrollably and refused any food thereafter for about four days.

Finally what happened to Yanick? His master never came back to report to me about his progress. But after about a month, I learnt from a friend that Yanick had won a good number of prizes at the recent dog show at the Kennel club. Which meant that he was disease-free.

So, I presumed that my valiant attempt at canine dermatology, was successful at the very first and hopefully last attempt.



Dr Kingshuk Chatterjee
Associate Professor, NRS MCH



THE LONE RANGERS KANHA RESERVE FOREST



CUTICON WB 2025

The 28th Annual State Conference of the IADVL West Bengal Branch was convened on 15th and 16th November at Vivek Tirtha, New Town, Kolkata. The academic proceedings were preceded by pre-conference workshops on 14th November, focusing on Dermatosurgery at Medical College, Kolkata, and Dermatopathology at NRS Medical College, Kolkata. These workshops facilitated in-depth academic engagement through live procedural demonstrations and discussions on distinctive dermatological cases.

The subsequent two days of the conference were marked by high-level scientific deliberations delivered by distinguished faculty from across the state and the country. Eminent speakers, including Abir Saraswat, C. Brijesh, Sanjeev Handa, Sujay Khandpur, Anand M., Bhabani S. T. P. Singh, Suman Patra, and Vishal Gupta, contributed significantly to the academic richness of the event.

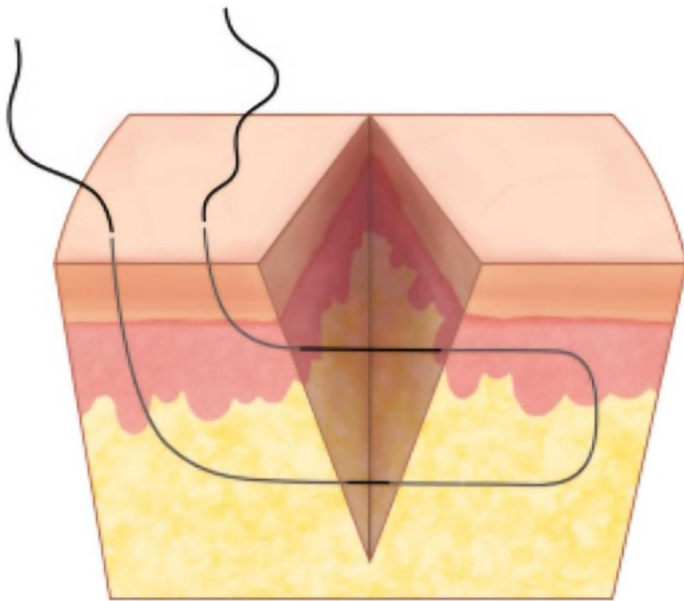
The inaugural session was noteworthy, graced by the esteemed presence of Prof. Sukumar Mukherjee and Swami Visakhanandaji Maharaj, the in-charge of Ramakrishna Mission, Vivek Tirtha. The conference also witnessed enthusiastic participation from postgraduate residents representing various medical colleges, particularly in the e-poster and award paper sessions. A major highlight was the IADVL-GSK National Quiz for postgraduates, which added a dynamic and engaging element to the academic atmosphere.

The comprehensive scientific programme curated by the Scientific Committee, combined with the meticulous planning and efficient execution by the Organising Committee, ensured that CUTICON WB 2025 concluded as a highly successful and academically enriching event.



Quiz Zone

1. What is the diagnosis? (PIC 1)
2. What is the diagnosis? (PIC 2)
3. What is the name of this suturing technique? (PIC 3)
4. 65 year old male presents with this rash.
What is the diagnosis? (PIC 4)
5. What is the diagnosis? (PIC 5)



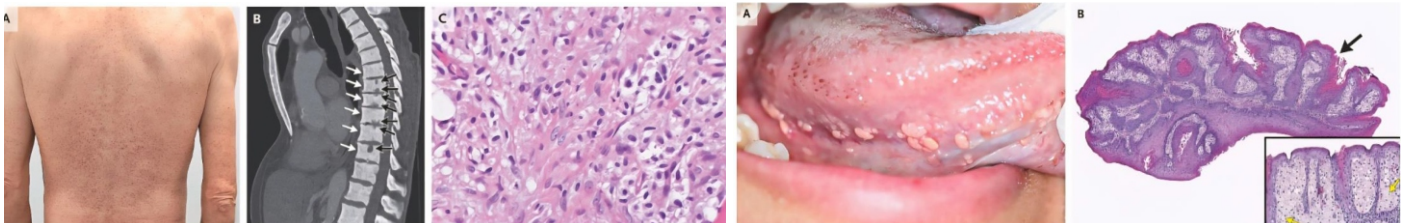
PIC 3



PIC 1



PIC 2



PIC 4

PIC 5

Quiz Answer Volume-3, Issue-7

1. Plumage sign, Pigmented Bowen disease.
2. Micromotor device for follicular unit extraction.
3. Pagetoid dyskeratoses.
4. Lenacapavir.
5. Androgenic alopecia. Araparkin body.

The correct response given: Dr. Shatanik Bhattacharya
for Quiz

Thank You for your answer and happy reading

Kindly send your entry to iadvlwb@gmail.com with 'Skintellect Quiz' as subject.
The correct response of each month gets acknowledged in the next issue.

Send your entries now!

Good luck from Team Skintellect.

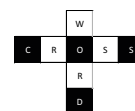
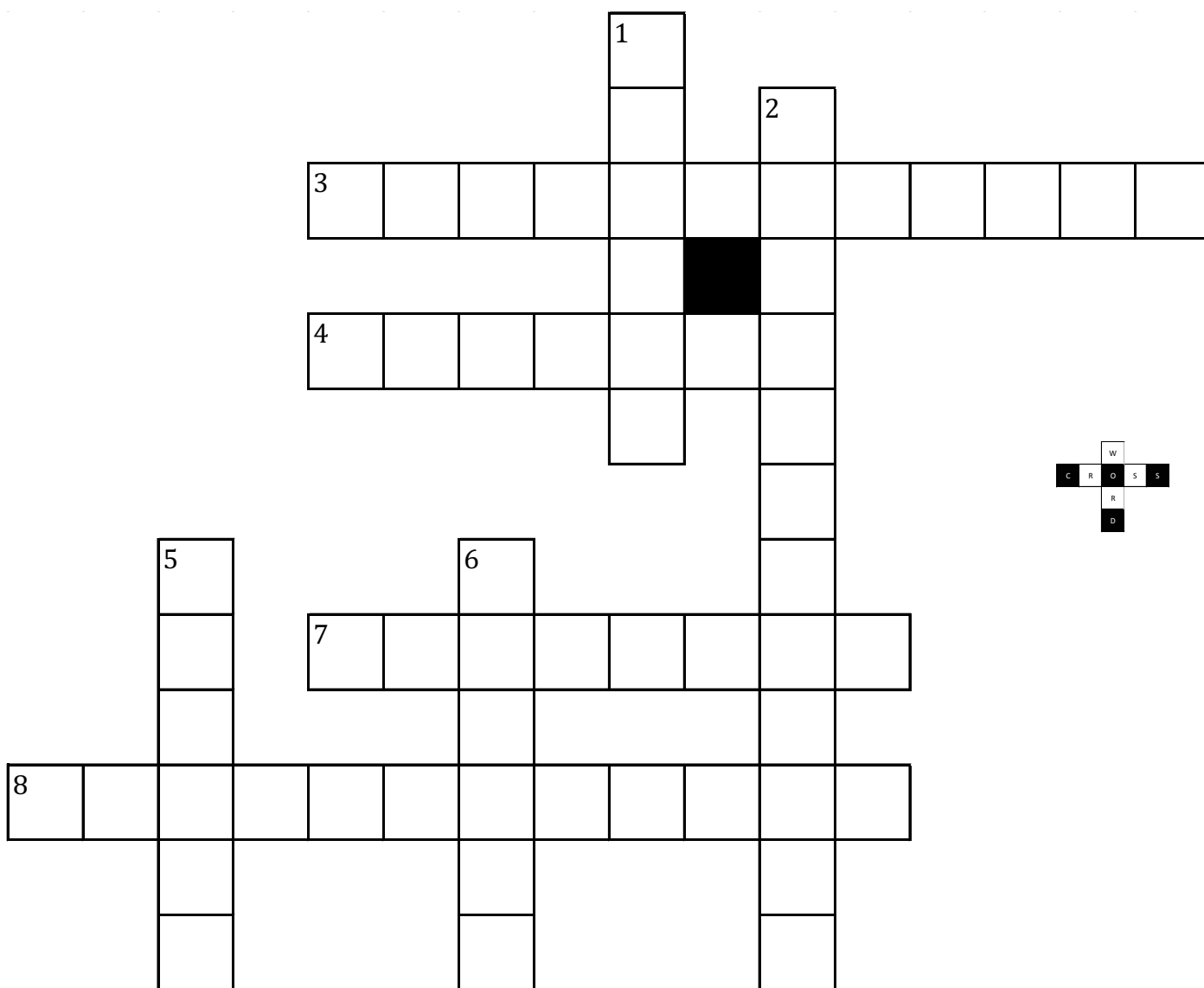
Brainstorm

Across

3. IL-13 inhibitor approved for patients ≥ 12 years
4. City where the first known leprosy asylum was established in early 19th century
7. Dermoscopy sign characteristic of traction alopecia
8. A new gonococcal vaccine candidate, completed Phase III in 2023; priority review in June 2025

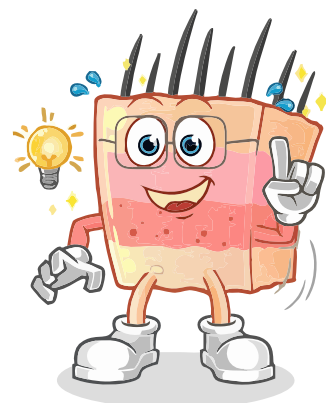
Down

1. Triad of hyperandrogenism, insulin resistance, and acanthosis nigricans in women
2. Non-steroidal anti-androgen blocking androgen receptor, used in FPHL
5. “___flap”: keloid surgery where top layer is separated from main mass
6. orange-colored stain used in amyloidosis



Dermwiz

I
arrive
ragged, raw, A
solitary wound that
multiplies strife. Name
me: The ulcer that cries
louder than it looks,
The culprit spread by
fleeting fire, The
culprit whose
pain reveals



Dermwiz Answer
Volume-3, Issue-7

gonorrhea

