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

SKINTELLECT

The Official Newsletter of the IADVL West Bengal State Branch

Issue Spotlight

"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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SKINTELLECT
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Note from the President

Dear Esteemed Members and Colleagues,

Warm greetings to all.

The month of February has once again reflected the academic vibrancy and collective commitment of IADVL West Bengal towards continuous learning and meaningful professional engagement.

*On **10th February**, we successfully organized an insightful **Webinar on Leprosy**, reaffirming our enduring responsibility toward a disease that continues to demand clinical vigilance, early diagnosis, and compassionate patient care. Despite remarkable advances in dermatology, leprosy remains socially and medically relevant, and such academic initiatives help reinforce updated knowledge while strengthening our resolve toward stigma reduction and improved community dermatology services. I sincerely thank the organizers, faculty members, and enthusiastic participants who contributed to the success of this program.*

*Continuing our academic momentum, on **22nd February**, we conducted a highly enriching **SIG Activity on Contact Dermatitis, Eczema, and Pruritus at Novotel, Kolkata**. The program brought together experienced faculty and young dermatologists in a stimulating academic environment, facilitating practical discussions on commonly encountered yet clinically challenging dermatoses. The interactive deliberations, evidence-based insights, and exchange of real-world experiences truly exemplified the spirit of collaborative learning that defines our association.*

*I am also delighted to share an important editorial initiative introduced in this issue of Skintellect. We have dedicated special pages to highlight the **achievements of our members**, with the aim of showcasing excellence within our dermatology community. Our colleagues continue to excel in academics, research, leadership, and service at regional, national, and international levels. Recognizing and celebrating these accomplishments not only honours individual contributions but also inspires younger members and strengthens our collective professional pride.*

Such academic engagements and recognition initiatives reflect the evolving vision of IADVL West Bengal — one that promotes learning, collaboration, mentorship, and celebration of excellence.

As we move forward, let us continue to nurture curiosity, encourage academic dialogue, and uphold the highest standards of dermatological practice while remaining sensitive to the needs of our patients and society.

I extend my sincere appreciation to all office bearers, organizing teams, faculty members, contributors, and participants whose dedication keeps IADVL West Bengal dynamic and progressive.

With warm regards and best wishes,

Dr. Dinesh Kr. Hawelia

President

IADVL WB

SKINTELLECT
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Volume 3 Number 11
March 2026

Secretary's Scribes

Dear Members,

The Indian Association of Dermatologists, Venereologists and Leprologists (IADVL) West Bengal chapter continues to uphold its steadfast commitment to academic excellence and clinical advancement, fostering a culture of continuing medical education and meaningful professional collaboration among its members.

On the occasion of IADVL Leprosy Day, the IADVL WB Academy organized a dedicated webinar on 10th February 2026, focusing on contemporary and clinically relevant aspects of leprosy. Esteemed faculty members including Dr. Somnath Sarkar, Dr. Rajesh Kr. Mandal, and Dr. Supratim Saha delivered insightful deliberations on Diagnosis of Leprosy – Today and Tomorrow, Residual Skin Lesions after Leprosy: Active Disease or Sequelae, and Disabilities in Leprosy – Current Scenario. The program culminated in a stimulating case-based panel discussion addressing challenging clinical scenarios. The session concluded with an engaging interaction and vote of thanks by the undersigned. With 73 registered participants, the webinar was a resounding success, reinforcing the importance of early diagnosis, disability prevention, and sustained efforts toward stigma reduction.

*A comprehensive SIG academic program titled "**The Itchy Rash: More Than Skin Deep**" was conducted under SIG Eczema–Contact Dermatitis–Pruritus in association with the West Bengal State Branch of IADVL. This CME initiative delivered focused and practice-oriented sessions on Atopic Dermatitis, Chronic Pruritus, Contact Dermatitis, Ethical Practice in Dermatology, and recent advances in moisturizers. The scientific highlights encompassed cutting-edge updates in the pathogenesis and therapeutics of atopic dermatitis, the neurobiology of pruritus with practical management algorithms, case-based discussions on refractory pruritus, occupational and cosmetic dimensions of contact dermatitis, and ethical considerations in dermatological practice.*

The context and vision of the CME were eloquently set by the Coordinator, SIG ECDP, Dr. Rajesh Verma. The academic proceedings were enriched by eminent national faculty including Dr. Neel Prabha, Dr. Soumya Srirama, and Dr. Guneet Awal, alongside distinguished senior state faculty members such as Dr. Sumit Sen, Dr. Sanjay Ghosh, Dr. Dinesh Hawelia, Dr. Soumya Panda, Dr. Sudip Das, Dr. Sudip Kumar Ghosh, and Dr. Indrashis Podder, supported ably by several promising junior faculty members. The vibrant panel discussions and enthusiastic delegate participation ensured that the sessions were both intellectually stimulating and practically impactful.

We are also pleased to announce the commencement of a new series of Clinical Meetings for the year 2026, beginning on 27th February at R. G. Kar Medical College and Hospital. Continuing our established academic tradition, these meetings aim to promote structured case-based discussions and dynamic academic exchange among faculty members, practicing dermatologists, and postgraduate trainees.

I extend my sincere gratitude to all faculty members, organizers, and delegates for their unwavering support and active participation in advancing the academic mission of IADVL West Bengal. I encourage every member of our esteemed association to engage wholeheartedly in the branch's activities so that together we may continue to elevate our standards and carry our flag ever higher.

With warm regards and best wishes,

Dr. Suchibrata Das
Honorary Secretary
IADVL WB

SKINTELLECT
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Volume 3 Number 11
March 2026

Editors Desk

Dear Readers

The month of March witnessed a vibrant array of academic activities, reflecting the dynamic spirit of our association.

The academic calendar commenced with a webinar in observance of World Leprosy Day on 10th February, which featured enriching discussions and enthusiastic participation from members. The deliberations were insightful and highlighted the continued relevance of collaborative academic engagement.

The SIG–Eczema, Pruritus & Contact Dermatitis CME, held on 22nd February 2026 at Novotel Kolkata, saw active participation from eminent dermatologists across India. The event fostered stimulating discussions on commonly encountered clinical challenges in our daily practice, making it both practical and intellectually rewarding.

The month concluded on a high note with the Clinical Meet at R.G. Kar Medical College, which witnessed an excellent turnout and robust academic interaction.

In this issue, we have dedicated an entire section to celebrate the academic achievements of our esteemed members at both national and international platforms. Their accomplishments and contributions continue to inspire the entire fraternity.

This month's spotlight shines on our incoming IADVL Secretary, Dr. Somenath Sarkar, who graciously shares glimpses of his professional journey and outlines his vision for IADVL WB.In the Dermbuzz section, Dr. Oindrilla Dutta discusses periorbital hyperpigmentation and under eye rejuvenation, while in the Residents' Corner, Dr. Sayoni Ghosh highlights emerging sexually transmitted infections that merit attention in contemporary practice.

The Dermaginations section once again features a humorous and engaging write-up by Dr. Arijit Coondoo, sure to bring a smile amidst a busy clinical schedule.

We encourage all our readers to actively read, engage, and contribute to the newsletter to ensure its continued success.

Happy reading!

Dr. Kaushiki Hajra
Editor, Skintellect,
The IADVL WB Monthly Newsletter

SKINTELLECT
The Official Newsletter of the IADVL West Bengal State Branch
Volume 3 Number 11
March 2026

DERMATOLOGIST SPOTLIGHT: DR. SOMENATH SARKAR

What motivated you to take dermatology and share your journey with the subject over the years.

Skin is the largest organ of the body and it is the window to see the internal organs as well.

Many dermatological diagnoses are made by careful clinical examination and pattern recognition without heavily relying on lab investigations. Dermatology is a unique combination of scientific knowledge, clinical judgment, diagnosis and medical management along with different procedures like LASER, peels, minor surgeries, Botox, fillers, etc., which offers variety in daily practice.

Compared to other specialties, dermatology is known for predictable duty hours making it more attractive for long-term career sustainability. So these are factors that attracted me towards dermatology.

Coming to the second part of your question, in the initial days during residency, I learned morphology of skin diseases, differential diagnosis, different procedures, basic procedures and developed clinical judgment. After that when I, joined Medical Education Service and started practicing, I developed diagnostic speed and accuracy, built up patients' trust and reputation. I always try to keep updating myself through journals, conferences, CMEs, etc. After becoming Professor of Dermatology, I have shifted from volume to value.

Throughout my career, I have tried to do some research work, teach undergraduate and postgraduate students, mentor the juniors and maintain long-term relationships with patients, students and seniors. I always admit my failures and successes and always try to provide emotional care along with medical treatment.

Please share with us one of each challenging case of STI and leprosy that you have encountered in your career so far.

Challenging cases of Hansen's disease and STIs need both clinical skill and emotional resilience because of the complexity and atypicality of clinical manifestations, social stigma, and long-term follow-up.

Leprosy still remains a problem in society, not due to bacilli, but due to delay in diagnosis, nerve damage, and social stigma. Vague anaesthesia, subtle paresthesia, and minimal skin lesions compatible with leprosy require sharp clinical suspicion. Newer diagnostic tools like infra red thermography, FNAC for infiltrated lesions, nerve conduction velocity (NCV) study, and high-resolution ultrasound (for confirmation in pure neuritic cases) must be appropriately performed.

Managing lepra reactions with systemic steroids, MDT, and balancing associated co-morbidities is often more difficult than the disease itself. Even in the 21st century, patients hide the disease from family and workplace, so sometimes you have to treat the fear more than the disease. Patients should be adequately counseled to complete the full course of treatment.

For STIs, atypical presentations, multiple infections, partially treated cases, and steroid-modified cases should be carefully interpreted. Patients may present with overlapping features, requiring thorough clinical evaluation and counseling.

Fear of disclosure, denial, relationship conflict, anxiety and stress are often disproportionate to clinical severity. In such situations, a dermatologist should play the role of counsellor, educator and clinician.

Atypical presentations (like aphthous mimicking herpes genitalis, large necrotic lesion, persistent lesion and many others), differentials of STIs, and interpretation of serological results have to be done according to real-life experience and clinical scenarios.

SKINTELLECT
The Official Newsletter of the IADVL West Bengal State Branch
Volume 3 Number 11
March 2026

How significant is it to know histopathology slide review by the dermatologist themselves rather than depending solely on the pathology report?

It is very important for the dermatologist to review histopathology slides themselves. Reviewing the slide helps in reducing medical misdiagnosis, enables faster therapeutic decisions, and both the patient and the doctor feel more confident in difficult cases regarding diagnosis and treatment modalities.

When the pathologist prepares the report, they often have only the slide and a short clinical history, whereas the dermatologist has the full clinical history and examination findings.

In certain borderline situations such as inflammatory dermatoses, psoriasiform reaction patterns, lichenoid pattern, different granulomatous reactions, and many other conditions, it is very important to perform proper clinico-pathological correlation.

You have great publications, Sir. In this regard, what would you advise young dermatologists. How early should they start publication and why is it so important for moulding their career?

According to me, the young fellows should start publishing articles during their residency or within the first one to two years of their clinical practice. Simple case reports, case series, or brief communications are ideal to begin with. I feel all seniors and mentors are always ready to help them.

Coming to the second part of your question, when a young dermatologist prepares a paper, they are compelled to review the differentials, examine histopathology repeatedly, and read existing literature regarding similar cases. These process increases in-depth knowledge regarding the case.

Publications also open career doors for fellowships, teaching roles, conference faculty invitations, academic appointments, institutional credibility, and patient trust, among many others. It sharpens observation skills, deepens knowledge, builds credibility, and quietly shapes the entire career of a young dermatologist.

If you are going to be the next Honorable Secretary of IADVL West Bengal Branch, what new changes would you like to bring with this position?

Being an incoming Secretary of IADVL West Bengal, I would like to strengthen CMEs in different medical institutions in both physical and hybrid modes. Clinico-pathological correlation seminars along with interdisciplinary collaboration will be my priority.

I plan to organize different hands-on workshops and various SIG workshops. I am also wish to launch a mentorship and research support programme along with a digital communication system for seamless communication and professional guidance. Also, planned for member welfare support scheme.

I would like to focus on standardizing clinical protocols for different diseases, making them evidence-based and patient-friendly in consultation with experts. I also wish to strengthen anti quackery cell, women dermatology cell, cultural cell of IADVL WB. Also wish to democratize, decentralize, digitalize the organization further more.

Additionally, I aim to organize multiple community outreach programmes and conduct high-quality midterm CME, Zonal and state conferences.

What are the hobbies that you like to do in your leisure time?

I have a passion for listening to music and enjoy literature. I am an avid traveler and also love to engage in social works. I have an NGO and in my leisure I used to engage in its welfare work.

SKINTELLECT
The Official Newsletter of the IADVL West Bengal State Branch
Volume 3 Number 11
March 2026

DERMBUZZ : PERIORBITAL HYPERPIGMENTATION– A REFIED APPROACH TO UNDER-EYE REJUVENATION

Dr. Oindrila Dutta
Consultant Dermatologist, Kolkata

The eyes are often described as the most expressive feature of the face. Yet, even subtle darkening around them can alter how we are perceived — creating an impression of fatigue, stress, or premature ageing.

Dark circles under the eyes are one of the most common aesthetic concerns I see in my practice. In dermatological terms, it is known as ***periorbital hyperpigmentation****; a condition affecting both men and women of all age groups.*

While often dismissed as a cosmetic issue, I have noticed individuals suffering from low self-esteem and how they feel.

Little do we know, advanced dermatological treatments have proven to offer personalized, effective cure — but the key lies in understanding the cause first.

Overview of Periorbital Hyperpigmentation

Periorbital hyperpigmentation refers to darkening of the skin around the eyes. It may appear brown, bluish, purplish, or even slightly shadowed depending on the underlying cause and skin type.

The under-eye area is unique. The skin here is thinner, more delicate, and has a rich vascular network. Even small changes in pigmentation, blood flow, or skin thickness can become visibly prominent.

Because this condition has multiple causes, treatment must be individualised rather than "one-size-fits-all."

Why Does Periorbital Hyperpigmentation Occur?

There is rarely a single reason. Most patients have a combination of factors:

1. ***Genetic Predisposition***
   Some individuals are naturally more prone to pigmentation around the eyes. This is especially common in certain skin types.
2. ***Melanin Deposition***
   Increased melanin production can cause brownish dark circles. This may worsen due to sun exposure or chronic rubbing of the eyes.
3. ***Vascular Causes***
   When blood vessels under the thin under-eye skin become more visible, the area may look bluish or purplish. Lack of sleep can exaggerate this appearance.
4. ***Structural Shadowing***
   Loss of volume in the tear trough area creates hollowness. The shadow formed gives the illusion of darkness, even if pigmentation is minimal.
5. ***Lifestyle Factors***
   Poor sleep, stress, dehydration, allergies, and excessive screen time can all contribute.
   Understanding the exact cause is the foundation of successful treatment. Treating vascular dark circles with only creams, for example, will not give significant improvement.

Dermatological Approach to the Treatment

In our clinical practice, we prefer to start with a detailed assessment of our patients. This includes:

- *Medical history*
- *Lifestyle evaluation*
- *Skin type analysis*
- *Examination under proper lighting*
- *Identifying pigment vs. vascular vs. structural causes*

Only after identifying the dominant factor the treatment plan is designed. The aesthetic treatment for periorbital hyperpigmentation is usually multi-layered and may involve one or more modalities.

SKINTELLECT
The Official Newsletter of the IADVL West Bengal State Branch
Volume 3 Number 11
March 2026

Suitable Treatments for Periorbital Hyperpigmentation

1. ***Topical Therapy***

Topical agents form the cornerstone of treatment, particularly in pigment-predominant POH. Commonly used formulations include:

- *Tyrosinase inhibitors such as kojic acid, arbutin, and azelaic acid*
- *Antioxidants including vitamin C derivatives*
- *Niacinamide for barrier repair and pigment modulation*
- *Mild retinoids in low concentration to enhance epidermal turnover*
- *Caffeine-based formulations for associated vascular congestion*

Given the sensitivity of periorbital skin, hydroquinone is generally avoided. Emphasis should be placed on barrier-supportive moisturisers to minimise irritant dermatitis.

2. ***Chemical Peels***

Superficial chemical peels can be beneficial in selected patients with epidermal pigmentation. Preferred agents include:

- *Lactic acid (20–30%)*
- *Mandelic acid*
- *Low-strength glycolic acid peels-Combination peels with antioxidants and brightening agents with vitc, kojic acid, ferrulic acid.*

Peels should be performed at intervals of 3–4 weeks, using conservative protocols to reduce the risk of post-inflammatory hyperpigmentation, especially in darker skin types.

3. ***Laser Therapy***

Laser treatment is effective for specific cases, especially when pigmentation or vascular visibility is prominent.

Different laser wavelengths target different concerns:

- *Pigment-targeting lasers reduce melanin, e,g-Low-fluence Q-switched Nd:YAG laser for dermal pigmentation, Picosecond lasers for resistant pigment*
- *Long-pulsed Nd:YAG laser for prominent vascularity*
- *Non-ablative fractional lasers to improve skin texture and fine rhytides*

Laser settings must be customised to skin type to avoid complications.

4. ***Tear Trough Fillers***

When structural hollowness is the primary cause, dermal fillers may be used to restore volume in the under-eye area. By reducing shadowing, the area appears brighter and more refreshed.

Low G' hyaluronic acid fillers placed in the deep plane for infraorbital hollows due to the complex vascular anatomy of the periorbital region. These procedures should only be performed by experienced clinicians.

5. ***Regenerative Therapies***

Platelet-rich plasma (PRP) and skin-boosting treatments including mesotherapy using agents such as tranexamic acid, vitamins, and antioxidants enhance dermalquality, improve thickness, and revitalise the under-eye region. These therapies are especially beneficial when thin, translucent skin contributes to darkness.

The Importance of a Combined Approach

In most patients, dark circles are multifactorial. For example, someone may have mild pigmentation, some vascular visibility, and early tear trough hollowing.

In such cases, combining treatments gives the best outcome.

A carefully layered plan may include:

- *Topical maintenance therapy*
- *Laser sessions for pigment correction*
- *Volume restoration where required*
- *Regenerative treatments to enhance skin quality*

The goal is not simply to lighten the area but to restore overall harmony and natural brightness.

What Results Can Be Expected?

Improvement timelines vary depending on the treatment selected and the underlying cause. Pigment correction may require several weeks of progressive therapy, while filler-based correction can offer immediate contour enhancement.

However, it is important to understand that periorbital hyperpigmentation often requires maintenance. Genetic predisposition cannot be permanently eliminated, but it can be effectively managed.

The objective is enhancement and balance — not artificial brightness. Subtlety defines success.

Safety, Expertise, and Precision

The periocular region/under-eye region is delicate and anatomically complex. Any treatment performed here requires:

- *Thorough knowledge of facial anatomy*
- *Conservative technique*
- *Proper patient selection*
- *Sterile and controlled environment*

When managed correctly by a trained dermatologist, these treatments are generally safe and well-tolerated.

Lifestyle Modifications That Support Treatment

As a dermatologist, we can initiate the change, but treatments work best when supported by healthy habits:

- *Adequate sleep*
- *Sun protection, including sunglasses*
- *Avoiding chronic eye rubbing*
- *Managing allergies*
- *Staying hydrated*
- *Balanced nutrition*

These small steps significantly enhance long-term results.

From a Dermatological Perspective

Periorbital hyperpigmentation is not merely a cosmetic concern; it is a multidimensional condition requiring expertise and nuance. In today's aesthetic landscape, we are fortunate to have refined tools that allow for precise, individualised care.

The goal is not transformation — it is restoration. A refreshed gaze, a softened contour, and a naturally luminous under-eye area that reflects vitality rather than fatigue.

With the right diagnosis and a considered approach, dark circles can be addressed gracefully and effectively — allowing your eyes to reclaim their central role in expression and confidence.

SKINTELLECT
The Official Newsletter of the IADVL West Bengal State Branch
Volume 3 Number 11
March 2026

RESIDENT'S CORNER: NEWER AND EMERGING STIS

Dr Sayoni Ghosh
2nd year PGT, NRS MCH

Sexually transmitted infections (STIs) continue to be widespread in the 21st century, posing a significant global burden on both public health and economic systems. There has been a recent increase in the transmission of STIs. Concurrently newer and atypical sexually transmitted infection have emerged. This can be attributed to a combination of agent, host, and environmental factors. These include changes in the pathogens' virulence characteristics and modes of transmission; host-related factors such as shifts in behaviour, including increased oral and anal sexual practices and behavioural changes within high-risk populations; and environmental influences, particularly growing globalisation and expanded social connectivity . All these increase the likelihood of atypical transmissions. Some newly emerging infectious agents, traditionally transmitted through food, water, or vectors, are now expected to spread via sexual contact. These emerging sexually transmitted infections may pose greater risks than conventional STIs due to the distinct methodological and epidemiological challenges they present for public health authorities and researchers.

Monkey pox- *It is a viral zoonotic disease caused by the monkeypox virus and is most frequently reported among men who have sex with men (MSM). Transmission occurs through close contact with infected skin lesions, body fluids, respiratory droplets, or contaminated fomites. Increased human–animal interaction due to deforestation, along with the discontinuation of routine smallpox vaccination, has contributed to a rise in cases. Classically, monkeypox presents with fever, headache, and lymphadenopathy, followed by a characteristic rash that evolves from macules to papules, vesicles, and pustules. In recent presentations, however, patients may develop fewer lesions, often confined to the anogenital and perioral regions. Complications such as proctitis and tonsillitis have also been reported. Diagnosis is confirmed by RT-PCR testing. Management is mainly supportive, though antivirals used for smallpox, including cidofovir and brincidofovir, have demonstrated therapeutic benefit.*

Zika virus- *It is a mosquito-borne flavivirus primarily transmitted by the Aedes aegypti mosquito. In addition to vector transmission, it can spread through sexual contact, blood transfusion, and transplacental transmission. Sexual transmission has been documented in both heterosexual and homosexual individuals.Approximately 80% of infected individuals are asymptomatic or experience mild, self-limiting symptoms lasting 2–7 days, including fever, maculopapular rash, conjunctivitis, headache, arthralgia, and myalgia, with fatalities being rare. Neurological complications, most notably Guillain–Barré syndrome, may occur. Diagnosis is established using nucleic acid amplification tests (NAAT). Management is supportive, as no specific antiviral therapy is available. The CDC advises abstaining from sexual activity for at least three months after symptom onset or after the last potential exposure in asymptomatic individuals.*

Ebola virus- *It belongs to the Filoviridae family, with fruit bats serving as its natural reservoir. Transmission to humans occurs through contact with bat excreta or the consumption of infected bats, as well as through intermediate hosts such as antelopes and great apes used as bushmeat. Person-to-person spread takes place via direct exposure to the blood, body fluids, or tissues of infected individuals, and vertical transmission from mother to fetus has also been documented.The incubation period ranges from 2 to 21 days. Clinical features include fever, vomiting, diarrhea, headache, abdominal pain, and episodes of unexplained bleeding. Diagnosis is confirmed by RT-PCR testing of blood samples. Management is largely supportive, focusing on maintaining fluid and electrolyte balance, providing oxygen therapy, and treating associated infections. Inmazeb, a monoclonal antibody therapy, has demonstrated effectiveness in clinical trials.*

Neisseria meningitidis *– It has a distinctive mode of transmission in this context, occurring predominantly through oral sexual contact. The organism is transferred from the normal upper respiratory tract flora of a sexual partner to the exposed individual, where it can cause urethritis. This mode of transmission has been observed in both heterosexual and homosexual encounters. Many affected individuals remain asymptomatic or present with mild symptoms such as urethral discharge and dysuria.*

SKINTELLECT
The Official Newsletter of the IADVL West Bengal State Branch
Volume 3 Number 11
March 2026

Genital tuberculosis- *Sexual transmission of tuberculosis is rare but has been documented, particularly in cases of male genital TB involving the penis or epididymis. Primary female genital TB can occur through sexual contact, and asymptomatic cases have been identified through active screening and genomic analysis. Therefore, early screening of female partners is recommended once male genital TB is diagnosed, even in the absence of symptoms.Genital TB generally spreads through prolonged intimate contact, making it more common among long-term partners rather than casual encounters. Male genital TB typically presents with epididymal swelling and systemic symptoms, although bacterial shedding is uncommon. In women, genital TB most frequently affects the fallopian tubes, followed by the endometrium and ovaries, and is often asymptomatic, with infertility being the most common presentation. Prevalence among infertile women is significant, with recent analyses reporting rates of approximately one-third of cases.*

Tinea genitalis- *It is an emerging form of genital dermatophytosis involving the mons pubis and labia in women and the penile shaft in men, with possible extension to the groin and scrotum. Although not a true sexually transmitted infection—since it spreads through close skin-to-skin contact rather than body fluids—it is relevant in sexual health due to its genital involvement, which is otherwise uncommon in tinea infections.Transmission occurs through sexual contact, autoinoculation, and misuse of potent topical corticosteroids, particularly in hot and humid climates. In India, a recent epidemic has been linked to Trichophyton mentagrophytes genotype VIII (T. indotineae), with predominantly human-to-human spread. Increasingly, zoophilic dermatophytes are also implicated. Lesions may be inflammatory or abscess-like, and diagnosis can be challenging, as routine cultures are insufficient; molecular testing is required for definitive species identification. Treatment often requires prolonged antifungal therapy. Evaluation of sexual partners and screening for other STIs are recommended when tinea genitalis is suspected.*

Giardia lamblia- *It is the most common intestinal protozoal parasite. Sexual transmission has been documented, particularly among men who have sex with men (MSM), with practices such as anal–penile and oral–anal contact increasing the risk of infection. Although many cases remain asymptomatic, symptomatic individuals may develop diarrhea, malabsorption, and abdominal cramping one to two weeks after exposure. Treatment options include metronidazole, tinidazole, or nitazoxanide.*

Entamoeba histolytica- *They are acquired with oral anal sex. Most MSM affected with amoebiasis are colonised with E.dispar but E.histolytica associated disease can also occur. It can be asymptomatic or develop invasive disease like amoebic colitis and liver abscess. For treatment metronidazole or tinidazole along with iodoquinone or paramomycin is given.*

Shigella - *Shigella infection is mainly caused by Shigella sonnei, S. flexneri, S. boydii, and S. dysenteriae. Clinical symptoms usually develop 1–4 days after exposure and include fever, abdominal pain, and bloody diarrhea. If not appropriately treated, the infection may progress to complications such as chronic colorectal strictures and fistula formation. The disease is reported more frequently among men who have sex with men (MSM). Diagnosis is established through stool culture or PCR testing. Management involves antimicrobial therapy, commonly with cephalosporins or fluoroquinolones, although the emergence of resistant strains is an increasing concern.*

Hepatitis A- *Transmission occurs via oral- anal, digito-anal and genito-anal contact. Most commonly seen in MSM. Infection is typically acute and self limiting. Hepatitis A vaccination is recommended in high risk population such as traveller to endemic areas, MSM, drug users and chronic liver disease.*

The incidence of these STIs is likely to continue rising due to increased global travel and the widespread use of digital platforms facilitating sexual contacts. Early testing and prompt treatment are essential, particularly among vulnerable populations such as men who have sex with men (MSM) and sex workers. People living with HIV require special attention, as many emerging STIs are highly prevalent in this group. Strengthening surveillance systems with organism identification (culture and genomic methods) and accessible treatment at the primary health-care level is crucial for effective control of emerging STIs.

SKINTELLECT
The Official Newsletter of the IADVL West Bengal State Branch
Volume 3 Number 11
March 2026

DERMAGINATIONS: PAGING PASSION BEYOND PRACTICE

WORDPLAY

Dr Arijit Coondoo
Ex-President, IADVL, WB

All patients, irrespective of age, sex and religion have the impression that doctors' handwritings are not at all legible. I don't blame them. Because I also carry almost the same impression. But with a difference. The axiom is not universally true. There is a minority whose handwriting is legible.

Fortunately, according to many of my patients, I do belong to that group.

However, there is a small minority with a fixed mindset. No matter how clearly I write, they refuse to believe that the pharmacist will be able to read my prescription. And this impression is forcefully conveyed to me in a not-so-polite manner.

I, in turn, politely return the implied insult by making them read the entire prescription themselves. And when they get through without a hitch, instead of feeling embarrassed, they will mutter under their breath something implying that it is my fault that I am an exception.

But then, sometimes complications can also occur with a patient's hearing rather than their visual acuity. This is understandable because when they hear the unfamiliar names of drugs, the result may be confusing for the patient and frustrating for the doctor. And positively hilarious for the audience.

Towards the end of the past century, I had a patient – a lady who had the idiosyncrasy of conversing mainly in questions.

She was my bank manager's wife. And he was a person who helped me a lot with my fiscal problems. Hence she was a VIP of sorts.

She would bombard me with questions regarding the diagnosis, type of disease, how I decided she had the disease, why I was writing whatever I was prescribing, what the side effects of the drugs were, how long she would take to get cured, and on and on and on.

Every visit from her would seem like a grand viva in the MD examinations.

But I had to reply to every question extremely patiently. After all, she was a lady and a VIP.

The icing on the cake of my misery was a phone call I received from her one day.

I had written an antibiotic that was not available in any pharmacy.

So I replaced that medicine verbally with another antibiotic.

Since she was a bit short of hearing, I had to shout out the name of the antibiotic "HOSTACYCLINE".

The ensuing conversation sent my wife (who was overhearing it) into peels of laughter, though she only heard my part of the dialogue.

"Doctor, what was the name?"

"Hostacycline" I shouted, realising that she couldn't hear properly.

"Why are you shouting? Am I deaf? Please repeat it in a normal voice."

SKINTELLECT
The Official Newsletter of the IADVL West Bengal State Branch
Volume 3 Number 11
March 2026

"Ok. Hostacycline" I said in a lower but slightly higher than normal decibel.

"Can you say that a bit slowly?"

"OK." I repeated the name slowly.

"Still can't get you. Can you spell it out so that I can write it down?"

"Ok. H O S T A C Y C L I N E" I spelled it out slowly for her benefit.

My ordeal was not yet over.

The lady was very angry by now.

"But doctor, the name is so long I still can't get it."

" OK Write it down now".

Ever so helpful I tried to spell the name by the Geographical route.

"H for Hongkong. O for Orlando. S for Sweden. T for Trinidad....." And on (I went.

Thinking out the names of 12 places for 12 letters was quite a daunting task for me.

Exhausted at the end of this theoretical geographic tour, I let out a deep breath.

But then something was not ok.

There seemed to be an eerie silence at the other end.

And then the lady came back, "Doctor, it was so wonderful. So poetic. I have never heard anything like this before. I was so mesmerized I forgot to write it down. Can you please repeat it?"

Repeat it? I was tired of this conversation. I was at the end of my wits. I wanted to bang down the telephone.(There were only landlines in those days}

But then she was a VIP. So I started off again.

Hardly had I said" H for Honolulu" than the lady yelled at me.

"Honolulu ? But you had said Hongkong earlier"

"It's the same thing. The H is important."

"No doctor. Honolulu and Hongkong are not the same. They are in different continents, in different parts of the world. Don't try to teach me. I have a postgraduate degree in Geography."

"And do you know why you doctors have such bad reputations. Because you are not consistent."

Tired, frustrated, traumatised, shattered.....I took two decisions

For the short term I changed to antibiotic to the much shorter "DOXT"

For the long term and for my own future safety I decided to shift my account to a different bank.

SKINTELLECT
The Official Newsletter of the IADVL West Bengal State Branch
Volume 3 Number 11
March 2026

In observance of World Leprosy Day
Webinar on Leprosy on 10/02/2026

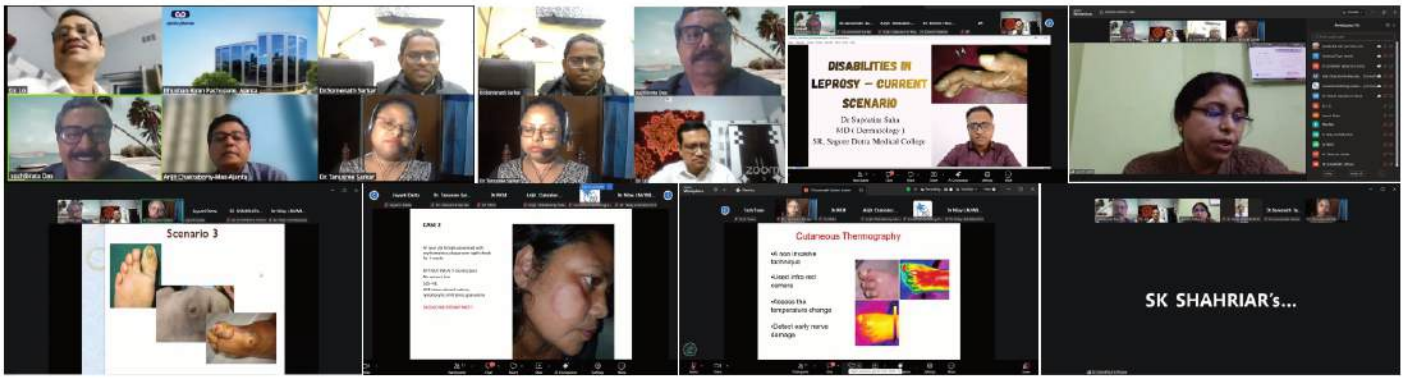
In observance of World Leprosy Day, the IADVL West Bengal branch hosted a specialized webinar on Tuesday, February 10, 2026. The session, which ran from 8:30 pm to 10:00 pm, served as a platform for high-level academic exchange and clinical updates.

The evening opened with a welcome address by Dr. Dinesh Kr. Hawelia (President, IADVL WB), followed by three focused technical sessions:

- *Dr. Somenath Sarkar: Diagnosis of Leprosy: Today & Tomorrow.*
- *Dr. Rajesh Kr. Mandal: Residual Skin Lesions: Active Disease vs. Sequelae.*
- *Dr. Supratim Saha: Disabilities in Leprosy: Current Scenario.*

A highlight of the event was the case-based panel discussion, "Difficult Scenarios in Leprosy," moderated by Dr. Jayanti Dutta. The panel—featuring Drs. Nilay Kanti Das, Lokenath Ghoshal, Suchibrata Das, SK Shahriar Ahmed, and Tanusree Sarkar—delved into complex therapeutic dilemmas, the emerging role of biologics, and management strategies for special populations.

The webinar concluded as a resounding success, equipping its 73 participants with valuable, updated insights into leprosy care.



Program Schedule		
Time	**Topic**	**Faculties**
08.30-08.35 pm	Introduction	Dr. Dinesh Kr. Hawelia *President, IADVL WB*
08.35-08.45 pm	Diagnosis of Leprosy: Today & Tomorrow	Dr. Somenath Sarkar
08.45-09.00 pm	Residual Skin lesion after Leprosy: Active disease or sequelae	Dr. Rajesh Kr. Mandal
09.00-09.15 pm	Disabilities in Leprosy: Current scenario	Dr. Supratim Saha
09.15-09.55 pm	Panel Discussion Moderator Difficult scenarios in Leprosy: Case based	*Moderator* Dr. Jayanti Dutta *Panelists* Dr. Nilay Kanti Das Dr. Lokenath Ghoshal Dr. Suchibrata Das Dr. SK Shahriar Ahmed Dr. Tanusree Sarkar
09.55-10.00 pm	Vote of Thanks	***Dr. Suchibrata Das*** *Hony.Secretary, IADVL WB*

SKINTELLECT
The Official Newsletter of the IADVL West Bengal State Branch
Volume 3 Number 11
March 2026

IADVL SIG
CME on Eczema, Contact Dermatitis & Pruritus on 22/02/2026

The Itchy Rash: More Than Skin Deep

The SIG Eczema–Contact Dermatitis–Pruritus CME was held on 22nd February 2026 at Hotel Novotel, Newtown, Kolkata, under the aegis of the Indian Association of Dermatologists, Venereologists & Leprologists in association with the IADVL West Bengal State Branch. The meeting brought together dermatologists from across the state for a focused academic programme marked by active participation and stimulating discussion. The event commenced with the inaugural ceremony, followed by the welcome address by Dr. Dinesh Hawelia and opening remarks by the organising committee.

The Atopic Dermatitis session, chaired by Dr. Sumit Sen, highlighted recent advances in pathogenesis and the expanding therapeutic armamentarium, including small molecules and biologics, and concluded with an engaging panel discussion on real-world management.

The Pruritus session, under the chairmanship of Dr. Sanjay Ghosh, provided valuable insights into the neurobiology of itch and a practical algorithmic approach to chronic pruritus. The case-based panel on refractory pruritus encouraged lively academic interaction and sharing of clinical experience.

The Contact Dermatitis session, chaired by Dr. Rajesh Verma, focused on hidden cosmetic allergens and the occupational perspective in recalcitrant hand dermatitis, followed by discussion of challenging cases that enriched the session with practical management strategies.

The concluding segment featured concise and practice-oriented updates by Dr. Indrashis Podder on ethical dermatology practice and recent advances in moisturizers. The programme ended with key take-home messages and a formal vote of thanks, followed by dinner.

The CME was academically enriching, well-structured, and highly interactive, reinforcing the importance of an evidence-based and multidimensional approach to eczema, pruritus, and contact dermatitis in contemporary dermatology practice.

SKINTELLECT
The Official Newsletter of the IADVL West Bengal State Branch
Volume 3 Number 11
March 2026

Monthly Clinical Meeting of IADVL WB on 27/02/2026 at R G KAR Medical College, Kolkata

This year's clinical meet kicked off at RG Kar Medical College. The meet was graced by Dr Kishaloy Ghosh , Dr Aniruddha Ghosh and Faculty of the Dept , Dr Sudip Kr Ghosh , Dr Jayasri Pramanik , Dr Ayan Samanta. Proceedings started with a Spectrum of Bullous Disease by Dr Ipsita Sarkar , constituting cases of Paraneoplastic Pemphigus , Pemphigus Vulgaris and Bullous ICD. A slew of cases of facial papules was presented by Dr Manisha Som next. Followed by The Spectrum of a Sinister disease: From Indolent to Aggressive presented by Dr Shinjon Pramanik , constituting case from CTCL to DLBCL to SPTCL. More cases presented were bullous morphea and lupus profundus by Dr Sweta Singh , BCC and Poroma by Dr Anarul Mondal , Nodular Amyloidosis by Dr Ankita Dey. The event was attented by a full house. The Faculty brilliantly guided the meet with their expert analysis and opinion.

SKINTELLECT
The Official Newsletter of the IADVL West Bengal State Branch
Volume 3 Number 11
March 2026

CELEBRATING EXCELLENCE: IADVL WB SHINES ON THE NATIONAL STAGE

We are immensely proud to recognize and celebrate the outstanding achievements of our esteemed members who have excelled at the national level:

- *Professor Dr. K C Kandhari Foundation Award: Dr. Sandipan Dhar*
- *IADVL Teacher Par Excellence Award (East Zone): Dr. Asok Gangopadhyay*
- *Fellow of Indian Academy of Dermatology: Dr. Sudip Kr. Ghosh*
- *Best Branch Award (State performing best in PLM conversion): IADVL WB*
- *Book Release: Herpes Virus Infection: Simplex and Varicella Zoster: A pictoreal treatise: Dr. Asok Gangopadhyay, Dr. Somenath Sarkar & Dr. Tanusree Sarkar. Postgraduate Dermatology: An Exam Preparatory Manual: Dr. Sudip Das, Dr. Shrayan Pal, Dr. Apeksha Singh*
- *Certificate of Appreciation –IADVL Academy Convenor: Dr. Nilay Kanti Das. IADVL Academy Member: Dr. Anupam Das*
- *Coordinator International liasion committee: Dr. Sandipan Dhar, Mental health committee: Dr. Koushik Lahiri, Convenor Quiz committee: Dr. Kingshuk Chatterjee.*
- *PG Thesis Award Paper session - DERMACON 2026: BEST AWARD PAPER (candidates less than 35 year): Dr. Rohan Barua*
- *Dr. Anirban Mukherjee, Dr. Somenath Das, Dr. Sudipta Roy, Dr. Aparesh Chandra Patra, Dr. Arghyaprasun Ghosh, Dr. Amrita Sil, et al. Effectiveness and safety of topical autologous platelet-rich fibrin membrane with total contact cast versus perilesional injectable autologous platelet-rich plasma therapy with total contact cast in trophic ulcer due to leprosy: A randomised controlled trial. Indian J Dermatol Venereol Leprol. 2025;91:163'--IJDVL Best Award Article published in the IJDVL in 2025.*
- *IADVL Observerships 2026: Dr. Priya Jaiswal (candidates less than 35 year) & Dr. Sujata Sengupta (candidates more than 35 year)*

Apart from these, we would also like to highlight some of the greatest Achievements by our esteemed members individually

***Dr. Sanjay Ghosh** delivered the prestigious 'Prof A K Bajaj Memorial Oration' at APEOD and CODFICON, an International Conference 31st October to 2nd November 2025 hosted by PGI, Chandigarh at Hyatt Hotel.Also authored the book ''Atlas & Synopsis of Contact & Occupational Dermatology', 3rd edition, has been released at APEOD & CODFI, International Conference, 31st November to 2nd November 2026 held at Hyatt, Chandigarh hosted by PGI.Prof Magnus Bruze, who wrote the 'Forewords' of the book himself was present in the ceremony!*

***Dr. Sudip Das** has been awarded with several new entitlements such as*

- *Vice president of IAASTDAIDS*
- *Editorial board member of IJSTDAIDS*
- *Member of Government Liason Committee, IADVL*
- *Convenor of Awards Committee, IADVL*
- *Chief Editor, Post Graduate Dermatology, Jaypee Publishers*

*Member of the Central Finance Council - **Dr Arijit Coondoo***

***Dr. Surajit Gorai** proudly represented SIG Aesthetics at the National IADVL program SIG TRISUMMIT (Acne, Laser & Aesthetics) held in Chennai on 8th–9th November. He is also Convenor of the same from this year onwards*

SKINTELLECT
The Official Newsletter of the IADVL West Bengal State Branch
Volume 3 Number 11
March 2026

Dr. Saumya Panda

- *Member, Central Finance Council*
- *Member, Internal Complaints Committee*

Dr.Koushik Lahiri

- *Elected President of the Psychodermatology Association of India(2025-26)-January 2025*
- *Invited to the annual meeting of the Association for Psychoneurocutaneous Medicine of North America at Orlando, USA- March 2025.*
- *Invited as a faculty at the first World Congress of Psychodermatology at Istanbul, Turkey- May 2025*
- *Invited as a faculty at the International Congress of Dermatology, Rome 2025- June 2025*
- *Felicitated at Liverpool by Royal College of Physicians as ITATSA was selected as a finalist for the highly prestigious Excellence in Patient Care Award. Dr. Arijit Coondoo from IADVL, WB played a pivotal role in this historic crusade over the years since the very beginning.-July 2025*
- *Invited at ACSI Gurukul as a Mahaguru(Senior Faculty) at Kochi.-August 2025*
- *Delivered Dr. Runa Mukherjee Oration at the 50th Annual Scientific Conference & CME of the Indian Railway Health Services at B R Singh Hospital, Kolkata- November 2025*
- *Delivered The IADVL Constitution Golden Jubilee Oration at Dermazone East & Cuticon ne State in Agartala- December 2025*
- *Appointed as the founding National Chairperson of the Mental Health Taskforce of the Association by the Executive body of IADVL- January 2026.*
- *Assigned as a member of of IADVL INTERNAL COMPLAINTS COMMITTEE- January 2026*

Dr. Siddhartha Das

- *Member of the IADVL Antiquackery Cell.*
- *Member of the recently formed IADVL Ethics Committee.*

***Dr. Sanjay Rathi**, Coordinator of SIG acne, received 3rd Best SIG from IADVL Academy (year 2025), given at Bangalore dermacon*

Dr. Anupam Das

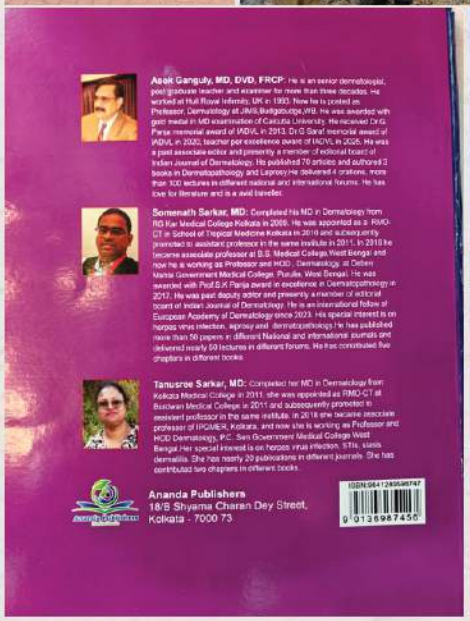
- *Featured in Top 2% scientists' list published by Stanford University (Elsevier), 2025*
- *Published a book - Sarkar R, Das A (eds.). Drugs and Therapeutics: Dermatology. 1st edition. Mumbai: Knowledge Bridge. 2026. ISBN 978-81-967525-1-4*
- *Published a book - Panda M, Das A. (eds.) Trending Topics : Pediatric Dermatology. 1st edition. Mumbai: Knowledge Bridge. 2026. ISBN 978-93-49413-89-4.*
- *Completed tenure as Member, IADVL Academy of Dermatology, 2024-2026*

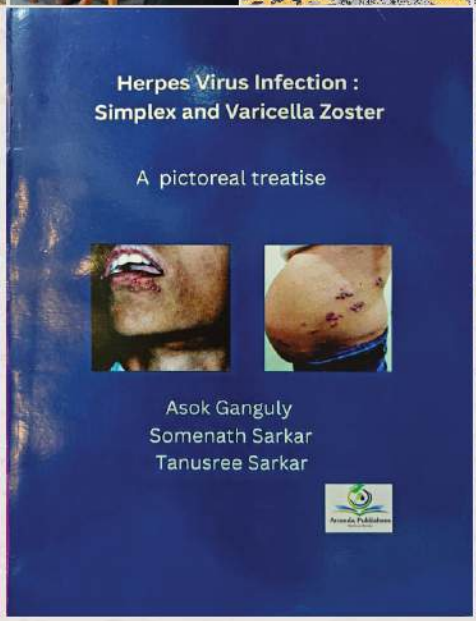
These achievements stand as a testament to their dedication, hard work, and pursuit of excellence. Their contributions not only bring pride to IADVL WB but also inspire others to reach greater heights. We extend our heartfelt congratulations and deepest appreciation to each of you. Let us continue to celebrate success and work together toward even greater accomplishments!

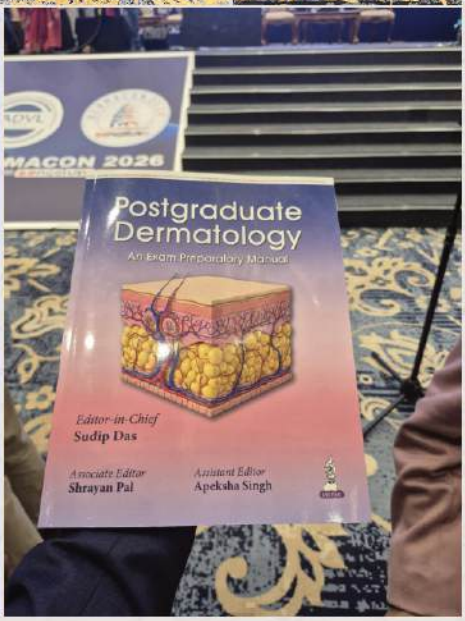
SKINTELLECT

The Official Newsletter of the IADVL West Bengal State Branch

Volume 3 Number 11
March 2026







SKINTELLECT

The Official Newsletter of the IADVL West Bengal State Branch

Volume 3 Number 11
March 2026

SKINTELLECT
The Official Newsletter of the IADVL West Bengal State Branch
Volume 3 Number 11
March 2026

Quiz Zone

1. *A full-term, previously healthy 1-week-old female was referred to pediatric dermatology for a growing face lesion that was present since birth Examination demonstrated a 1.;-cm violaceous nodule on the right upper cutaneous lip (Fig 1 a). A previously ordered ultrasound demonstrated a nonspecific heterogeneous echotexture of a well-circumscribed focus with ntrinsic vascularity Biopsy showed dermal histiocytic proliferation with Touton giant cells, positive for CD68, CD163, and factor XIIIa (Fig 1 b). What is the diagnosis?*
2. *A 77-year-old woman with a past medical history significant for venous insufficiency and hypothyroidism presented with a 1-year history of progressively worsening, intensely painful skin lesions. Initially, lesions appeared as thin, pink scaly plaques predominantly on her lower legs, which evolved into thick, yellow, horn-like crustec keratotic proiections associated with severe pain or palpation. What is the diagnosis? (Fig 2)*
3. *A 37-year-old female with hemophagocytic lymphohistiocytosis presented with sudden onset hair loss that evolved over several hours during admission for neutropenic fever. Examination revealed a well-defined, tender, violaceous alopecic patch with intact follicular ostia (Fig 3 a). A punch biopsy showed ulcer with nonspecific changes. All fungal, bacterial, and mycobacterial stains were negative. During hospitalization, she was diagnosed with methicillin-resistant staphylococcus aureus MRSA) bacteremia and discharged on intravenous daptomycin. She presented to the dermatology clinic 1 week later with worsening pain and hair loss, now with loss of follicular ostia (Fig 3 b). What is the diagnosis?*

Fig. 1 (a)

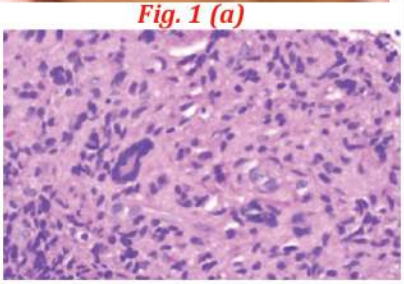
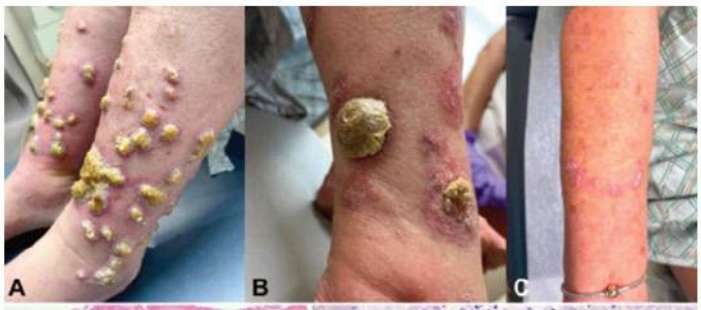


Fig. 1 (b)



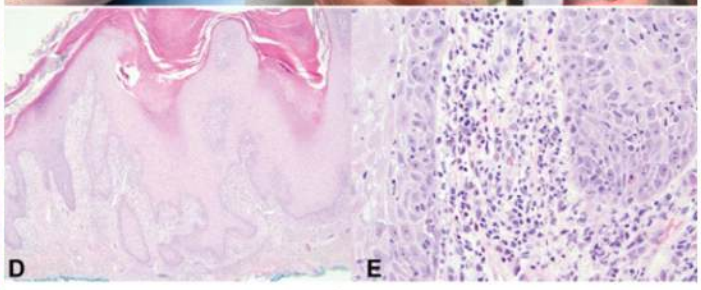


Fig. 2

Fig. 3 (a)

Alopecic patch on the occipital scalp with central erythema and ulceration.

Fig. 3 (b)

SKINTELLECT
The Official Newsletter of the IADVL West Bengal State Branch
Volume 3 Number 11
March 2026

4. *What are these skin sign called and in which nutritional disorder, it has been seen? (Fig 4)*
5. *A 50 years old females have bilateral symmetrical papules over dorsum of the hand for 3 years. What can it be? (Fig 5 a, b & c)*

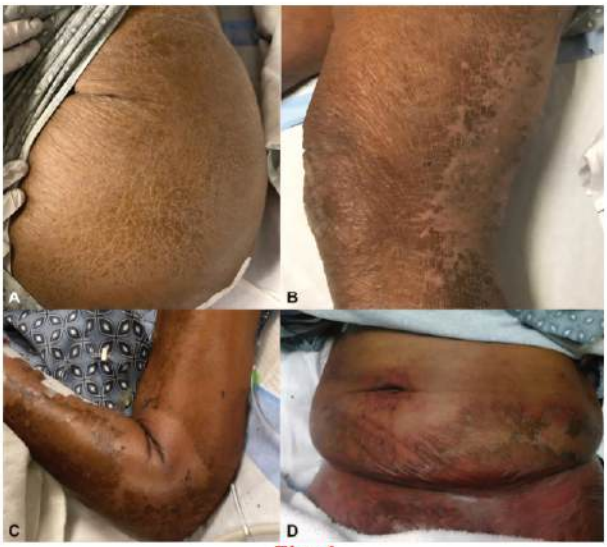


Fig. 4

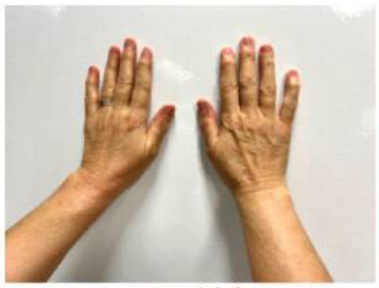


Fig. 5 (a)

Bilateral dorsal hands and distal forearms with numerous 2—5 mm, firm, dome-shaped, flesh-colored papules in a symmetric acral distribution.

Fig. 5 (b)

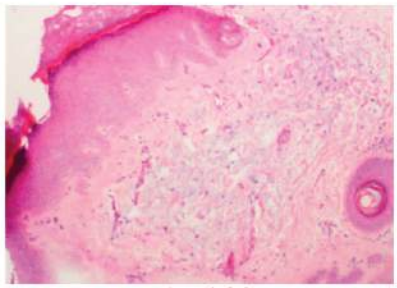


Fig. 5 {c}

Quiz Answer Volume-3, Issue-10

Q1. Gene defect- LEMD3 (aka MAN 1), Buschke ollendorff syndrome
Q2. Technique used-
Ans- BIOCHIP mosaic technique using indirect immunofluorescence test
Q3. Identify- Dr. Yellapragada Subbarow (synthesized methotrexate)
Q4. Procedure-
Ans- Intradermal thread insertion for browlift
Q5. These cells seen in-
Ans- Cytophagic histiocytic panniculitis(Bean bag cells)

The correct response given: Dr. Shatanik Bhattacharya for Quiz & Dermwiz

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.

SKINTELLECT
The Official Newsletter of the IADVL West Bengal State Branch
Volume 3 Number 11
March 2026

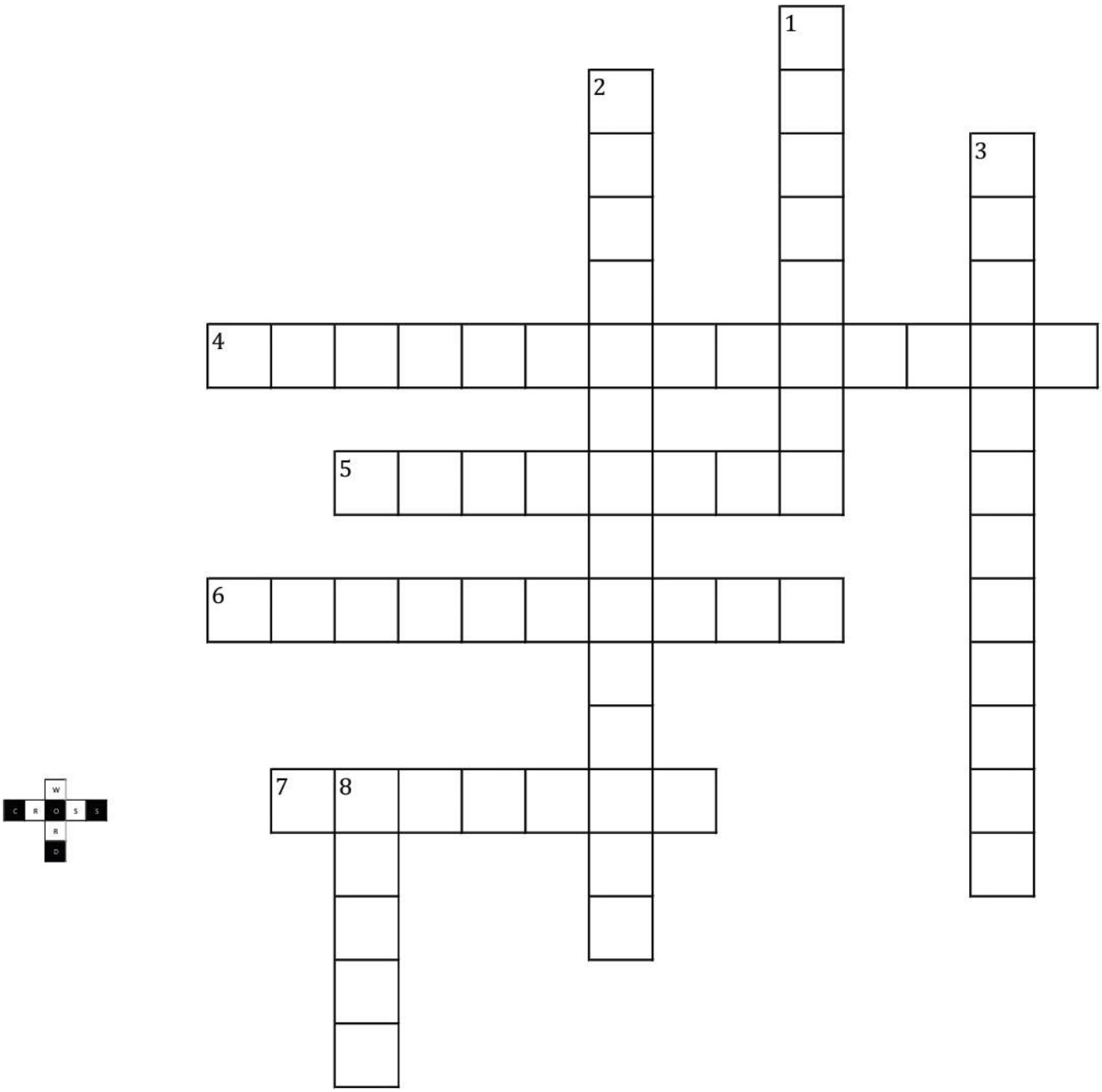
Brainstorm

Across

4. earliest histopathological feature of psoriasis
5. cell-free regenerative therapy and are a major emerging trend in dermatology and dermatosurgery.
6. Biologic for psoriasis with dose adjustment for weight
7. The triad of livedo reticularis, neurological deficit, and hypertension is characteristic of this syndrome:

Down

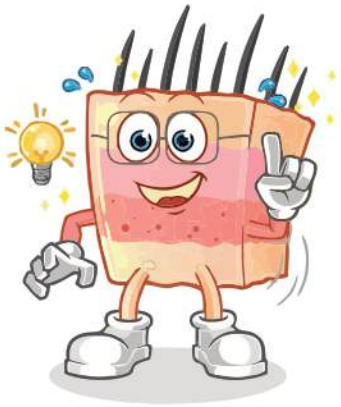
1. Doxycycline post-exposure prophylaxis (Doxy-PEP) is now recommended for prevention of
2. Central white scar-like area with peripheral pigment network suggests
3. most recent FDA-approved oral therapy under investigation for and rogenetic alopecia?
8. Best suture for facial skin closure



SKINTELLECT
The Official Newsletter of the IADVL West Bengal State Branch
Volume 3 Number 11
March 2026

Dermwiz

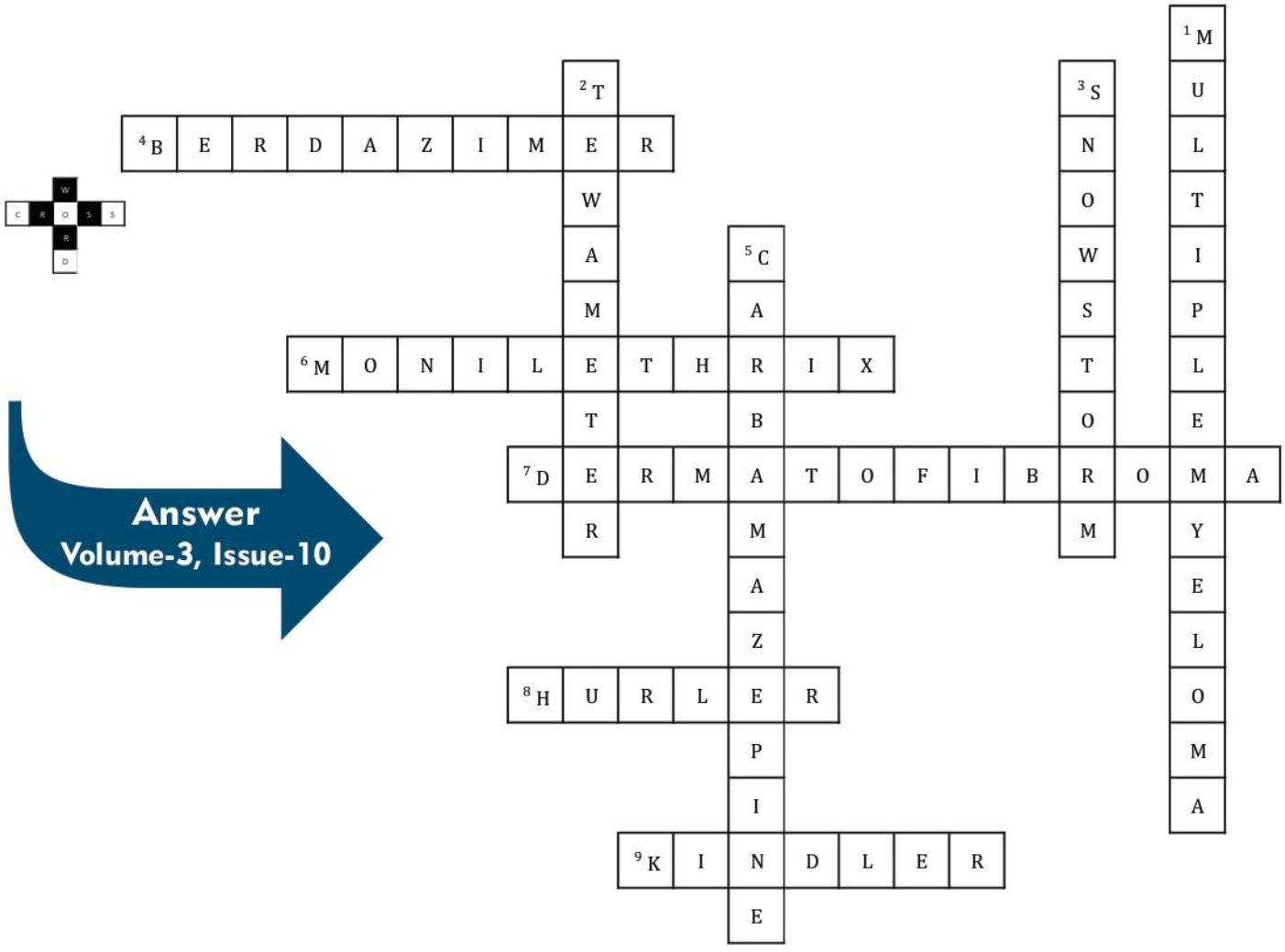
Not
adolescent folly,
Yet comedones
persist.
Elastin undone by light long
kissed.
Periocular caverns,
Solar script in skin.
Two names remember
Where photons win.
Who am I?



Dermwiz Answer
Volume-3, Issue-10

pityriasis versicolor

Answer
Volume-3, Issue-10



Save the Date

INDIAN ASSOCIATION OF DERMATOLOGISTS VENEREOLOGISTS & LEPROLOGISTS
IADVL
1973
WEST BENGAL STATE BRANCH

14th Mid Term Conference

Experience and dynamicity shapes the future of Dermatology

27th & 28th June 2026

Venue

Anticlock Suites & Resorts, Dhaldangamore
Bankura

REGISTRATION FEES

Category	1/4/2026 30/4/2026	1/5/2026 10/6/2026	11/6/2026 On Spot
Life Member	₹ 1500/-	₹ 2500/-	₹ 3000/-
Accom Person	₹ 1000/-	₹ 2000/-	₹ 2500/-
PG Student	₹ 750/-	₹ 1500/-	₹ 2000/-
Cancellation	50%	25%	NIL

Programme Highlights

- *Clinical dermatology*
- *Leprosy*
- *STI*
- *Aesthetics*
- *Award paper sessions and e poster for PGTs with prizes*
- *Free paper session for LMs & PGTs with prizes*
- *Young dermatologists' forum*
- *Quiz for PGTs*

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Save the Date

dermazone east cuticon wb 2026

32nd Zonal Conference of IADVL & 29th Annual State Conference of IADVL WB

27th, 28th & 29th November 2026

DERMAZONE EAST

32nd East Zonal Conference of IADVL **&** 29th Annual State Conference of IADVL WB Branch

CUTICON WB 2026

Organised by

IADVL West Bengal State Branch

BBCC, Kolkata