NEWSLETTER

DERM-CONNECT

INDIAN ASSOCIATION OF DERMATOLOGISTS,
VENEREOLOGISTS AND LEPROLOGISTS
(DELHI STATE BRANCH)

APRIL–JUNE 2024 VOLUME 1 ISSUE 1

THEME:

UPCOMING DRUGS & TECHNOLOGY IN DERMATOLOGY

MESSAGE FROM PRESIDENT, IADVL-DSB - Dr. GULHIMA ARORA

Dear DSB members,

We are two-months into our tenure, and friends, it is an honor for me to pen this message as the President of IADVL Delhi State Branch to unfold the First Issue of the Branch Newsletter of the year 2024-25.

In continuation with the tradition of the previous EC of releasing quarterly issues of the Newsletter, we bring to you this excellent compilation of the first of the four issues. And what better occasion than the Mid-Cuticon of the Delhi State Branch to release the same! Our sincere thanks go out to Dr. Pooja Arora Mrig, for doing excellent justice as Editor of this issue and to Dr. Shikha Gupta for helping with the co-ordination of bringing this compilation to you.

The content of the Newsletter comprises the activities undertaken by the Branch From 01 April 2024 till date. These activities have been in accordance with the National Directives, and we are thankful to the entire EC and Branch Members for their unflinching support towards them. A special message of gratitude goes out to the entire State Branch for their solidarity extended toward the Guinness World Record Pledge Campaign, where Delhi achieved a total pledging number of 44 percent. This was indeed a unique opportunity to come together and pledge about creating awareness about the importance of consulting a qualified skin specialist for dermatological and venereological conditions.

The two monthly meetings held till now have yielded an overwhelming response in terms of attendance form both, senior and junior colleagues. Hosted by Base Hospital Delhi Cantonment and ESI Hospital Basaidarapur, these academic meetings were par excellence in terms of learnings.

This issue of the newsletter also brings about a myriad of articles pertaining to the vast panorama of Dermatological topics and has something of interest for every reader. The brain-teasing quiz is a sure grey-cell stimulator. The articles by erudite authors are surely a not-to-miss. Our Instagram handle by the name **@iadvl.delhi** is now active and all announcements, greetings and some brain teasers are posted there. The support of the post-graduate students deserves special mention and applause, in their participation towards the video competition on World Skin Health Day as well as for the Pledge Campaign. With warm regards, I wish to take you through the pages of this newsletter.

Thanking you,
Dr. Gulhima Arora, President IADVL DSB 2024-25

MESSAGE FROM HONORARY SECRETARY, IADVL-DSB - Dr. HIMANSHU GUPTA

Dear DSB members,

As the Hony Secretary, IADVL Delhi State Branch, I welcome you all to enjoy the contents of the first issue of the newsletter of the year 2024-25, the theme of which is 'Upcoming drugs and technologies in Dermatology'. The articles shared by eminent dermatologists in our city are concise and well-informative. In addition, we are excited to share with all of you, the remarkable journey we have experienced over the previous two months, working for the State Branch.

As far as this quarter's activities are concerned, the turnout in the two monthly meets, one at Army Base Hospital and the other at ESI Hospital, Basaidarapur, was admirable and the cases were well-received. We also attempted to spread awareness in community on World Skin Health Day on 6th April about avoiding application of topical steroid creams and getting treatment from a qualified skin specialist for their skin disease.

Lastly, I would like to thank the branch members for their support towards the IADVL attempt for Guinness World Record Pledge campaign, thereby creating awareness among general public about the importance of consulting a qualified skin specialist for their skin issues. We have been given a daunting responsibility which we will strive to fulfil. Together we shall endeavour to take our branch to even greater heights. Long live IADVL!

Thanking you,
Dr. Himanshu Gupta, Hon. Secretary IADVL DSB 2024-25

INVITING ARTICLES

Those who are interested in publishing their articles in the next issues of IADVL-DSB newsletter can mail them to: **dr_shikhaarora@yahoo.co.in**

OUR TEAM

EDITOR'S NOTE

It brings me immense pleasure to bring to you the first issue of the newsletter "DERM-CONNECT" from IADVL-DSB (2024-25). The enthusiastic and dynamic team for this year, led by Dr Gulhima, is working hard to bring to you engaging activities and initiatives that will benefit the branch members.

The newsletter, one of the ongoing activities, is an attempt to keep everyone updated of what's the latest in our branch. The theme for the current issue is "UPCOMING DRUGS AND TECHNOLOGIES IN DERMATOLOGY." As we all know dermatology has made swift progress in the last decade with several advances in medical therapeutics as well as technological innovations. Several new molecules are being discovered adding to the armamentarium of treatment options available for our patients. We have new technological advancements both in the area of diagnosis and treatment. All this has revolutionized our approach in treating our patients. We can now hope for improved outcome, increased efficiency, and greater patient satisfaction.

This newsletter is the product of hard work put by our contributors who all happen to be eminent dermatologists in the city. Dr Vinay Singh has given a concise overview of abrocitinib highlighting the points to be taken care of while prescribing the drug. Dr Sandeep Arora, an expert in the field of biologics, has given an outline of IL-17 inhibitors in psoriasis. Dr Geeti Khullar, with her expertise in pediatric dermatology, has shared her experience with crisaborole. Dr Soni Nanda, a renowned aesthetician, has shared insights on newer chemical peels. Apart from this, we have valuable contributions from Dr Deepak Jakhar, Dr Rashmi Sharma and Dr Savitha Sharath. Our young residents, Dr Aishwarya Muddebihal and Dr Abhinav Bansal, have contributed a photoquiz and crossword respectively. Dr Chander Grover, a distinguished DSB member, aims to create awareness in her article about DVL welfare trust, the group insurance scheme that is being run by the IADVL.

Thanks to Dr Shikha Gupta, who is the coordinator for the newsletter and has worked tirelessly for the success of this venture. We all really look forward to the new term by the energetic team of Delhi State Branch.

We hope you enjoy reading this newsletter as much as we enjoyed in preparing it. Happy Reading and best wishes!

Warm regards,

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Dr RML Hospital & ABVL, New Delhi -110001
Section Editor, IJDVL
Member IADVL ACADEMY
Coordinator, IADVL-SIG (Pigmentary disorders)

REGISTRATION IS OPEN

SCAN THE QR CODE FOR REGISTERING

Dermazone North & Annual Cuticon DSB 2024

NAMASTE IADVL

IADVL DELHI STATE BRANCH

Date: 4th-6th October 2024

Theme: "Navigating the Frontiers of Dermatological Care"

Venue: The Leela Ambience Convention Hotel, Delhi

https://dermazonenorth2024.com/

contact@iadvldelhi.com

Registration Fees Details

Category	Early Bird Registration Till 1st July 2024	Normal Registration Till 1st Oct	Spot Registration After 1st Oct
PLM	₹ 4000	₹ 5000	₹ 6000
LM	₹ 6000	₹ 7000	₹ 8000
Accompanying person*	₹ 7500	₹ 7500	₹ 7500

*Accompanying person allowed only to visit trade area and for lunch on 5th & 6th October. Dinner for accompanying person on 5th Rs 2500/-

- For registered dermatologists - delegate kit, all lunches, visit to trade area and banquet on 5th October is included.
- 18% GST extra is applicable

Workshop Registration Fees

Workshop options: **A**. Lasers and devices **B**. Injectables **C**. Trichology

- Registration for any 1 workshop Rs 2000/-
- Registration for Hands on Trichology workshop additional Rs 1800/-
- Registration of 3 workshops Rs 5500/-

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ABROCITINIB: AN UPCOMING DRUG FOR DERMATOLOGICAL USE

Dr. VINAY SINGH, MD
Senior Consultant Dermatology,
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Abrocitinib is indicated for the treatment of adults by oral route with refractory, moderate-to-severe atopic dermatitis whose disease is not adequately controlled with other systemic drug products, including biologics, or when use of those therapies is inadvisable.

Mechanism of action

Abrocitinib is a Janus kinase (JAK)1 inhibitor. JAKs are intracellular enzymes which transmit signals arising from cytokine or growth factor-receptor interactions on the cellular membrane to influence cellular processes of haematopoiesis and immune cell function. JAKs phosphorylate and activate Signal Transducers and Activators of Transcription (STATs) which modulate intracellular activity including gene expression. Inhibition of JAK1 modulates the signalling pathways by preventing the phosphorylation and activation of STATs.

Absorption

Abrocitinib is well-absorbed with over 91% extent of oral absorption and absolute oral bioavailability of approximately 60%. The oral absorption of abrocitinib is rapid and peak plasma concentrations are reached within 1 hour. Steady-state plasma concentrations of abrocitinib are achieved within 48 hours after once daily administration. Both Cmax and AUC of abrocitinib increased proportionally up to 200 mg of dose. Abrocitinib and its active metabolites distribute equally between red blood cells and plasma.

Elimination

The elimination half-life of abrocitinib is about 5 hours. Abrocitinib is eliminated primarily by metabolic clearance mechanisms, with less than 1% of the dose excreted in urine as unchanged active substance. The metabolites of abrocitinib, M1, M2 and M4 are excreted predominantly in urine, and are substrates of OAT3 transporter.

Dosage

The recommended starting dose is 100 mg or 200 mg, by oral route, once daily based on individual patient characteristics:

A starting dose of 100 mg once daily is recommended for patients at higher risk of venous thromboembolism (VTE), major adverse cardiovascular event (MACE) and malignancy. If the patient does

not respond adequately to 100 mg once daily, the dose can be increased to 200 mg once daily.

A dose of 200 mg once daily may be appropriate for patients who are not at higher risk of VTE, MACE and malignancy with high disease burden or for patients with an inadequate response to 100 mg once daily. Upon disease control, dose should be decreased to 100 mg once daily.

The lowest effective dose for maintenance should be considered. Discontinuation of treatment should be considered in patients who show no evidence of therapeutic benefit after 24 weeks.

Laboratory monitoring

1. Complete blood count including platelet count, Absolute Lymphocyte Count (ALC) , Absolute Neutrophil Count (ANC) and haemoglobin (Hb) to be ordered before treatment initiation, 4 weeks after initiation and thereafter according to routine patient management.

2. Platelets: Treatment should be not be initiated or should be discontinued if platelet counts are $< 50 \times 10^3$ /mm^3.

3. ALC: Treatment should not be initiated or be interrupted if ALC is $< 0.5 \times 10^3$ /mm^3 and may be restarted once ALC returns above this value.

4. ANC: Treatment should not be initiated or be interrupted if ANC is $< 1 \times 10^3$ /mm^3 and may be restarted once ANC returns above this value.

5, Hb: Treatment should be interrupted if Hb is < 8 g/dL and may be restarted once Hb returns above this value.

6. Lipid parameters : Patients should be monitored according to clinical guidelines for hyperlipidaemia.

Drug Interactions

In patients receiving dual strong inhibitors of CYP2C19 and moderate inhibitors of CYP2C9, or strong inhibitors of CYP2C19 alone (e.g. fluvoxamine, fluconazole, fluoxetine and ticlopidine), the recommended dose should be reduced by half to 100 mg or 50 mg once daily.

Treatment is not recommended concomitantly with moderate or strong inducers of CYP2C19/CYP2C9 enzymes (e.g. rifampicin, apalutamide, efavirenz, enzalutamide, phenytoin).

In patients receiving acid reducing agents (e.g. antacids, proton pump inhibitors and H2 receptor antagonists), 200 mg once daily dose of abrocitinib should be considered.

Special populations

The use of abrocitinib in special populations has been described in detail in Table 1.

Contraindications

Renal impairment	• No dose adjustment is required in patients with mild renal impairment, i.e. estimated glomerular filtration rate (eGFR) of 60 to < 90 mL/min. • In patients with moderate (eGFR 30 to < 60 mL/min) renal impairment, the recommended dose of abrocitinib should be reduced by half to 100 mg or 50 mg once daily. • In patients with severe (eGFR < 30 mL/min) renal impairment, 50 mg once daily is the recommended starting dose. The maximum daily dose is 100 mg.
Hepatic impairment	• No dose adjustment is required in patients with mild (Child Pugh A) or moderate (Child Pugh B) hepatic impairment. Abrocitinib is contraindicated to patients with severe (Child Pugh C) hepatic impairment .
. **Elderly**	• For patients 65 years of age and older, the recommended dose is 100 mg once daily.
. **Paediatric population**	• At present abrocitinib is not recommended for use in pediatric population.
. **Women of childbearing potential**	• Women of reproductive potential should be advised to use effective contraception during treatment and for 1 month following the final dose of abrocitinib. • Abrocitinib is contraindicated during pregnancy & during breast-feeding.

Table 1: Use of abrocitinib in special populations

- Hypersensitivity to the active substance or to any of the excipients.
- Active serious systemic infections, including tuberculosis (TB).
- Severe hepatic impairment.
- Pregnancy and breast-feeding.

Special warnings and precautions for use

As there is a higher incidence of infections in the elderly and in the diabetic populations in general, caution should be used when treating the elderly and patients with diabetes. Risks and benefits of treatment prior to initiating abrocitinib should be considered for patients with chronic or recurrent infection; who have been exposed to TB; with a history of a serious or an opportunistic infection; who have resided or travelled in areas of endemic TB or endemic mycoses; or with underlying conditions that may predispose them to infection.

Tuberculosis- Patients should be screened for TB before starting treatment and yearly screening should be done. Abrocitinib must not be given to patients with active TB. For patients with a new diagnosis of latent TB or prior untreated latent TB, preventive therapy for latent TB should be started prior to initiation of treatment.

Viral reactivation- The rate of herpes zoster infections was higher in patients who were treated with 200 mg, 65 years of age and older, with a medical history of herpes zoster, with a confirmed ALC < 1 × 103 /mm3 prior to the event and patients with severe atopic dermatitis at baseline. If a patient develops herpes zoster, temporary interruption of treatment should be considered until the episode resolves. Screening for viral hepatitis should be performed in accordance with clinical guidelines before starting therapy and during therapy.

Vaccination- Use of live, attenuated vaccines should be avoided during or immediately prior to treatment.

Venous thromboembolism (VTE)- Events of deep venous thrombosis (DVT) and pulmonary embolism (PE) have been reported in patients receiving abrocitinib. In patients with known VTE risk factors other than cardiovascular or malignancy risk factors, abrocitinib should be used with caution. VTE risk factors other than cardiovascular or malignancy risk factors include previous VTE, patients undergoing major surgery, immobilisation, use of combined hormonal contraceptives or hormone replacement therapy, inherited coagulation disorder. Patients should be re-evaluated periodically during abrocitinib treatment to assess for changes in VTE risk. Promptly evaluate patients with signs and symptoms of VTE and discontinue abrocitinib in patients with suspected VTE, regardless of dose.

Major adverse cardiovascular events (MACE)- Events of MACE have been observed in patients taking abrocitinib. Therefore, in patients 65 years of age and older, patients who are current or past long-time smokers, and patients with history of atherosclerotic cardiovascular disease or other cardiovascular risk factors, abrocitinib should only be used if no suitable treatment alternatives are available.

Malignancy- Lymphoma and other malignancies have been reported in patients receiving JAK inhibitors, including abrocitinib. NMSCs have been reported in patients receiving abrocitinib. Periodic skin examination is recommended for all patients, particularly those who are at increased risk for skin cancer.

Immunosuppressive conditions or medicinal products- Patients with immunodeficiency disorders should not receive abrocitinib. Combination with biologic immunomodulators, potent immunosuppressants such as ciclosporin or other Janus kinase (JAK) inhibitors is not recommended.

Potential Treatment Emergent Adverse reactions

As with any immunomudulator therapy, the following treatment emergent ADRs are expected, although the incidence in all the studies done so far were comparable to the placebo or the incidence in general population. The most commonly reported adverse reactions are nausea, headache, acne, herpes simplex, blood creatine phosphokinase increased, vomiting, dizziness, and upper abdominal pain.

Conclusion

Abrocitinib is a targeted JAK inhibitor with very high affinity to JAK 1, hence is a specific JAK 1 inhibitor, the data collected so far is promising in the treatment of Atopic Dermatitis with itch relief experienced as early as 254 hours. It is a promising steroid sparing molecule.

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IL-17 INHIBITORS IN PSORIASIS MANAGEMENT

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Introduction

Psoriasis, a chronic, immune-mediated, inflammatory disease although still an incompletely understood disorder where genetic and epigenetic factors play a role continues to affect 2-3% of the world population. Management of this condition however, has seen tremendous progress with availability of biologic disease modifying drugs. The biggest change they have brought about is the earlier conceptual and now achievable concept of PASI 100 (and even beyond).

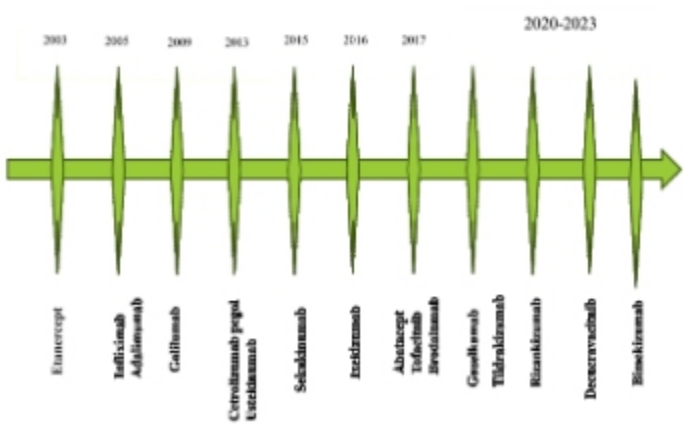

Figure 1. Timeline of biologics in psoriasis with their FDA approval

Timeline of psoriasis management

The step ladder pattern of psoriasis management still holds true and vast majority continue to benefit from topical therapy, phototherapy, nbUVB and the oral disease modifying agents. Rapid development of biologic disease modifying agents (bDMARDs) has brought about numerous molecules for clinical use as the following timeline shows[1]:

The role of cytokines in psoriasis pathogenesis and where does IL17 fit in?

Psoriasis now understood as a systemic inflammatory disorder is driven by T cell activation associated with the secretion of proinflammatory cytokines, tumour necrosis factor-α, interleukin (IL)-17A, IL-22, and interferon IFN-γ. This IL-23/IL-17 immunologic pathway plays an important role in promoting disease onset and progression. IL-17A, a critical effector cytokine in this pathway, effects tissue changes with precipitation and worsening of the skin and organ involvement.
Evidence to prove that IL17A upregulates psoriasis transcriptome as compared to IL22, increasing expression of psoriasis autoantigens ensuring enough expression to cause cutaneous and systemic inflammation. Amongst the IL 17 subfamily IL17A, C and F are implicated with IL17A being biologically far more active than the other two.

Making a case for IL17 inhibitors

The move to a biologic disease modifying drug is primarily dictated by the degree/ severity of disease, involvement of high impact areas, response to traditional disease modifying agents, joint and systemic involvement, comorbid conditions and the financial capacity of the patient.
In the scenario of a higher chance of tuberculosis, poorer compliance of a self-financed patient (scenarios of follow up dropouts and resultant intermittent therapy), rapidity of action and ease of use and administration, IL17 inhibitors score over other available molecules in our country. The chance of tuberculosis is far-far less compared to TNF-α inhibitors such as infliximab, etanercept and adalimumab, although all patients must be subjected to the same strict screening protocol as for any biologic DMARD. Literature shows a returning patient responds well to IL17 inhibitor after a gap as compared to reduced response to TNF-α inhibitors. Anti-drug antibodies have been found in negligible numbers and in those found did not result in clinical significance.[3]

Molecule	IL17 target	FDA approval
Secukinumab	IL-17A	2015 psoriasis, 2016 PsA
Ixekizumab	IL-17A	2016 psoriasis, 2017 PsA
Bimekizumab	IL-17A and IL-17F	2018 psoriasis
Brodalumab	IL-17RA (IL-17A, IL-17E, IL-17F)	2017 psoriasis

Table 1: Available IL17 inhibitor molecules

The available IL17 inhibitor molecules are listed in Table 1.

Ixekizumab has a more rapid onset of action, with comparative effects later in the treatment course. A switch within IL17 inhibitor class from Secukinumab failure to Ixekizumab has shown promising results.[4] The author has found similar efficacy in those earlier treated with Secukinumab and TNF-α inhibitors with relapses showing good results with Ixekizumab. As with all classes of molecules combinations with other oral medications may be necessitated in case to case basis.[5]

Pre-treatment Screening and indications

Threshold for a IL 17 biologic DMARD are the same as any other biologic DMARD.[6]
Full blood count, Liver enzymes, Renal function tests, Pregnancy test, CRP, HBV/HCV, HIV, IGRA/ Mantoux, Chest X-ray must all be done before instituting IL17 inhibitors.
Ask for a history of tuberculosis, hepatitis B or C infection, HIV and inflammatory bowel disease.

Contraindications

1. Active tuberculosis.
2. Latent tuberculosis detected must be given prophylaxis for 4 weeks and thereafter instituted on treatment
3. Inflammatory bowel disease:
   Although the incidence of denovo inflammatory bowel disease in patients treated wit IL17 inhibitors is the same as in the general population, it may unmask latent disease and hence those with known disease and with fresh symptoms need to be discontinued, investigated and referred for suitable management.

Criteria	Secukinumab	Ixekizumab
Indications	Plaque psoriasis, psoriatic arthritis	Plaque psoriasis (psoriatic arthritis in India awaited)
Dosage for Plaque Psoriasis (Adults)	300 mg at Weeks 0, 1, 2, 3, and 4 followed by 300 mg every 4 weeks	Two 80 mg injections for the first dose, followed by one injection every 2 weeks for the next 6 doses, and then one injection every 4 weeks
Dosage for Psoriatic Arthritis	With loading dosage: 150 mg at Weeks 0, 1, 2, 3, and 4 and every 4 weeks thereafter. Without loading dosage: 150 mg every 4 weeks	Two 80 mg injections for the first dose, followed by one injection every 4 weeks
Administration	Subcutaneous injection	Subcutaneous injection
Formulation	Injection, for subcutaneous use	Autoinjector for subcutaneous use

Table 2. Comparison of treatment protocols for Secukinumab and Ixekizumab in psoriasis

Side effects

Common side effects associated with this class of molecules is headache, nasopharyngitis, and infections.
Infections commonly associated with these are yeast infections with some series reporting up to 4.5% having candida disease.
Citrate in the auto-injector does lead to injection site reactions. These are somewhat more with Ixekizumab and Secukinumab.

Conclusion

IL17 inhibitors have shown a good clinical response in psoriasis vulgaris and psoriatic arthritis. Both Secukinumab and Ixekizumab have largely replaced TNF-α inhibitors in our biologic DMARD practice of moderate to severe psoriasis.
Overall it has been observed:

- Ixekizumab has demonstrated one of the highest cumulative cases of complete skin clearance and is most likely to maintain PASI100 (23 weeks per year) when compared to Guselkumab, Secukinumab, and TNF-α inhibitors.
- Additionally, Ixekizumab achieved the best patient satisfaction, attitude, and self-reported improvement scores compared to Secukinumab and Ustekinumab.
- In a real-life retrospective observational study, Ixekizumab led to a rapid and progressive improvement in average PASI (Psoriasis Area and Severity Index) and patient satisfaction.

- These positive clinical results were sustained for up to 4 years of continuous treatment, unaffected by specific factors such as gender, previous biologic therapies, or average BMI.[7]

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CRISABOROLE: A NON-STEROIDAL TREATMENT FOR ATOPIC DERMATITIS

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Department of Dermatology,
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Introduction

Atopic dermatitis is the most common inflammatory skin disease in children with increasing evidence of new onset and persistent disease in adults as well. Quality of life is impaired in atopic dermatitis irrespective of severity. While topical steroids and calcineurin inhibitors are proven to be effective, they are not devoid of side effects. Quest for an effective modality with minimal side effects and long-term safety continues. Crisaborole is one such new topical drug which was approved by the Food and Drug Administration (FDA) in 2016 for atopic dermatitis.

Mechanism of action

It works by competitive, reversible inhibition of phosphodiesterase- 4 (PDE-4) enzyme. This results in increased intracellular cyclic adenosine monophosphate (cAMP) levels, which reduce the production and effects of pro-inflammatory cytokines like IL-4 and IL-13.[1] In an intra-patient randomized trial of 40 patients, crisaborole significantly modulated key biomarkers versus vehicle, including Th2 and Th17/Th22 pathways and epidermal hyperplasia.[2]

Pharmacokinetics

Steady-state systemic concentrations are attained by day 8. It is highly (97%) bound to human plasma proteins and is substantially metabolized into 2 inactive metabolites. The mean half-life is 11.9 +/- 8.28 hours. The metabolites are excreted majorly through kidneys.[1]

Indications (FDA approved and Off label) and doses

FDA approved

1. **Atopic dermatitis:** Crisaborole is available as a 2% ointment and is indicated for use in mild to moderate atopic dermatitis in adult and pediatric patients. Initially in 2016, it was approved for patients 2 years of age and older, but in 2020 the lower age limit was extended from 24 months down to 3 months.

In a double-blind, vehicle-controlled phase III trial involving 1527 patients aged 2 to 79 years with mild to moderate atopic dermatitis, more patients in the crisaborole-treated group achieved treatment success.[1] Studies have shown improvement in pruritus as early as 24 hours.[2]

Clinical trials comparing 0.5% and 2% preparations, given either once or twice daily reported improvement in all 4 dosing regimens, but it was maximum in 2% twice daily regimen.[1] Thus, it is recommended that the ointment should be applied twice daily on the affected areas till clinical resolution.

In a recent randomized, double-blind, vehicle-controlled, 52-week, phase III study, once daily application delayed the onset of flare and resulted in a greater number of flare-free days and reduced number of flares.[3] This suggests that crisaborole can also be used as an effective long term maintenance therapy for chronic cases.

Currently, there are no head-to-head trials in literature comparing the efficacy of crisaborole with other available therapeutic options for atopic dermatitis like topical steroids and calcineurin inhibitors. A matching-adjusted indirect comparison of crisaborole ointment 2% vs. topical calcineurin inhibitors suggests that the odds of achieving an improvement in Investigator's Static Global Assessment scores (ISGA) score is greater with crisaborole 2% than with pimecrolimus 1% or tacrolimus 0.03%.[4] On the contrary,

another study reported topical corticosteroids as the most effective modality after adjusting for vehicle, followed by aryl hydrocarbon receptor agonists, calcineurin inhibitors and PDE-4 inhibitors.[5] More direct comparison studies with other topical drugs, efficacy in severe atopic dermatitis and cost benefit analysis are warranted to decide the role and position of crisaborole in the therapeutic ladder of atopic dermatitis.

The drug is available in India and a 30 gm tube costs around INR 700-800. In an Indian study of 19 patients aged 2-16 years old, crisaborole ointment significantly improved atopic dermatitis symptoms and was well-tolerated.[6]

Off label

It has been tried in cases of psoriasis, seborrheic dermatitis, vitiligo, inflammatory linear verrucous epidermal nevus, and stasis dermatitis, but currently the data and evidence for use in these conditions is limited.[7]

Contraindications

It is contraindicated in patients with known hypersensitivity to crisaborole or any component of the formulation.

Adverse effects

1. Hypersensitivity reactions: It presents as pruritus, swelling and erythema at the application site or at a distant site. Crisaborole should be immediately discontinued in these cases and symptomatic treatment be given.

2. Flare-up of existing lesions, application site pain, burning or stinging and infections were reported in long term safety trials but the rates were similar to patients treated with the vehicle.[1] The most commonly reported treatment emergent adverse effect (TEAE) was application site burning or stinging (4%), which is lower than the incidence reported with topical corticosteroids (1-6%) and topical calcineurin inhibitors (20-58%).[1] It is well tolerated in sensitive skin areas as well, where topical corticosteroids are often restricted.

3. Systemic side effects: Systemic absorption and exposure is limited. TEAEs potentially attributable to systemic PDE-4 inhibition, such as diarrhea, nausea, and vomiting have been reported infrequently. But no treatment-related safety findings due to systemic PDE-4 inhibition were observed in this long-term study.[3]

Use in special situations

There is insufficient human data for use during pregnancy and breastfeeding. Animal data does not suggest any adverse developmental effects.[1] No dosage adjustment is required for patients with renal or hepatic impairment.[1]

Drug interactions

Metabolite of crisaborole is a weak inhibitor of cytochrome (CYP) P450 enzymes 1A2 and 2B6 and a moderate inhibitor of CYP2C8 and CYP2C9. But since the systemic absorption is limited, no clinically significant drug-drug interactions have been noted.[1]

Conclusion

Crisaborole is an effective topical treatment for mild-moderate atopic dermatitis. Minimal side effects, limited systemic absorption and long- term safety in pediatric age group above 3 months are its advantages. Higher cost, lack of safety in pregnant and lactating population and lesser role in severe atopic dermatitis are a few drawbacks. More direct comparative efficacy studies with other therapeutic modalities are needed.

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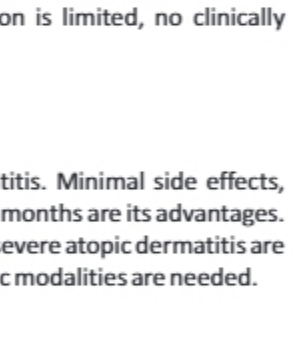
HERPES ZOSTER VACCINE: HYPE VERSUS EFFICACY



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Introduction

Herpes zoster (HZ) is caused by varicella zoster virus (VZV), a neurotropic herpesvirus and occurs secondary to reactivation and subsequent multiplication of virus which remains dormant in the sensory and vesicles limited to a dermatome innervated by dorsal root or cranial nerve ganglion along with the radicular pain and consequently causing debilitating post-herpetic neuralgia (PHN). Antivirals may shorten symptom duration and severity of the disease; however, they must be administered within 72 hours of symptom onset, and there is lack of evidence to demonstrate a benefit in the prevention of PHN.

Mechanism of action

The specific cellular immune response of host against VZV (particularly VZV-specific CD4 T cells) maintains the virus in a latent state and prevents its replication. Studies have shown no correlation between levels of anti-VZV antibodies and protection against HZ.[1] The drop in immune response below a critical threshold triggers an anamnestic immune response, halting viral replication and keep the reactivation subclinical. The episodes of such subclinical virus reactivation as well as exposure to contact with VZV infection, boosts VZV-specific immune response and these contained reversions limit the age dependent decline in VZV cell mediated immunity (CMI). However, incidence of HZ increases with age corresponding to decline in VZV CMI and higher prevalence of immunosuppressive conditions. The lifetime risk of HZ is approximately 50% for individuals reaching their eighth decade, with the elderly population having a higher likelihood of developing PHN.[2]

HZ vaccines restore the anti-VZV cellular immunity to prevent reactivation of latent VZV and thus acts more like a therapeutic vaccine. The amount of vOka (live-attenuated Oka vaccine strain of VZV) in zoster vaccine is 14 times more than the amount in varicella vaccine, as most adults have immunity to varicella.[3] It decreases the HZ reactivation considerably, thereby reducing complications such as PHN and post-herpes zoster stroke.[4]

Types of HZ vaccines

Currently, two vaccines are licensed for prevention of HZ including a live vaccine [zoster vaccine live (ZVL)] based on the attenuated vOka and a recombinant vaccine [recombinant zoster vaccine (RZV)] based on the VZV glycoprotein E (gE). RZV is recommended in immunocompetent adults > 50 years of age and considered superior to ZVL.[5] Single dose of ZVL (0.65ml) administered subcutaneously and FDA approved in adults with age >50 years, whereas RZV is approved in adults ≥18 years who are or will be at increased risk of HZ due to immunodeficiency or immunosuppression caused by known disease or therapy and given as two doses, separated by 2-6 months, intramuscular (0.5ml/dose) in deltoid region of the upper arm.

Efficacy

Overall efficacy of ZVL reported against HZ is 51% and protection wanes after 3 years and efficacy of RZV is 97% lasting for >10 years. The efficacy of ZVL and RZV in the prevention of PHN is 66% and 91% respectively.[4,6] While the younger population benefits from reduction in HZ incidence, older individuals benefit from decrease in disease severity and incidence of PHN. The efficacy of ZVL vaccine was found to decrease with the age of the recipient (51.3% in adults aged 60 years or over and 37.6% in those aged 70 or over).[7] Contrarily, sustained response to vaccination is observed with RZV, irrespective of the age of the vaccinees.

RZV also elicits strong and persistent immune response even in individuals with compromised immunity, including those undergoing transplant, cancer patients, or people living with HIV, but ZVL is not recommended for use in immunocompromised patients. However, RZV is more reactogenic compared to ZVL and serious adverse effects such as hypotension with syncope, mononeuritis, neurosensory deafness, and musculoskeletal chest pain have been reported within 30 days of vaccination.[8]

Conclusion

While the use of HZ vaccines is recommended in patients who are at higher risk of HZ, routine use in general population would add to the economic burden. Also, the need of HZ vaccines is still debatable as contained reversions offer intrinsic immunity against episodes of HZ. Although, the vaccination against HZ is promising in the light of current evidence, there are certain areas which need to be addressed, including the effectiveness of vaccine in immunocompromised patients and protection offered by these vaccines against post-herpes stroke. The efficacy of the vaccine is yet to be determined in populations with a lower seroprevalence of VZV antibodies, or having previously received the VZV vaccine. Further, long-term studies to firmly establish the role of RZV beyond 10 years and the need for booster dose are required.

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DECODING GFC MODIFIED PRP

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Introduction

PRP (platelet rich plasma) and GFC (growth factor concentrate) therapies have emerged as important therapeutic option in regenerative medicine and restorative treatment. PRP serves as an important treatment modality in dermatology, with its effective use and successful results, particularly in the field of hair restoration, skin rejuvenation, acne scars, dermal augmentation and stretch marks. Both the treatments are commonly recommended for optimum hair growth and as an emerging antiaging treatment.

The GFC concentrate is amalgamation of growth factors which stimulates the growth of hair follicle by stimulating the stem cell. It stimulates hair growth and promotes thickness of the hair. Recently, it has gained a lot of traction and popularity. The difference lies in the way they are conducted and the preparation of PRP. The similar contemplation was to begin with when the role of PRP was initiated in dermatology for several indications. At the present time we have enough literature to support the evidence of PRP.

The difference lies in both compliance and results associated with both the treatments.

What growth factor does GFC rely upon?

The growth factor contributes to stem cell proliferation, migration, and differentiation. It contains VEGF, PDGF, EGF, and IGF-1. GFC produces faster result.

PRP and GFC are hailed as the two most important treatments in hair loss.

There are several benefits of GFC modified PRP. There are several commercially available GFC kits like hydron, yuskin, follihair and trich kit.

Indications for GFC therapy

GFC, which is modified PRP, is most commonly used in trichology for several conditions like male and female pattern of hair loss, telogen effluvium, alopecia areata and hair transplantation. As per one study the role of GFC is highly evidenced in melasma.[1] GFC therapy has a promising role in androgenetic alopecia.[2] According to the study GFC therapy was found to have a promising role in the management of androgenetic alopecia in both male and female patients.[3]

It also offers significant improvement as antiaging treatments. As per one study, five months of application of MYOWNN™ serum showed a statistically significant improvement in an average of six parameters of anti-aging and face rejuvenation with a p-value of 0.0150 (<5% level of significance (i.e. 0.05) and was also well-tolerated.[4] Significant improvement was noted in parameters like aging spots, pores, wrinkles, texture, moisture, and pigmentation.

GFC Versus PRP

The two treatments are akin but there are some differences between the two treatment modalities (Table 1). The PRP treatment is operator dependent which means the quality of PRP would vary in various clinics. The GFC therapy is more uniform so it's less operator dependent hence can be more relied upon. The actual execution can vary from clinic to clinic. The second important difference lies in the clinical outcome. With PRP therapy there can be variety of dynamic factors which play a role causing results to vary and amount of time it takes vary person to person.

The level of comfort while undergoing GFC is more compared to PRP treatment. With the advent of GFC modified PRP the discomfort is ineffectual. However, the cost of the PRP is less than GFC modified PRP. The ease of comfort in preparation is also more in GFC modified PRP. The side effects reported were mild such as injection site pain, erythema, oedema, and bruising, and resolved spontaneously within a few hours to few days of onset.

Drawbacks with GFC modified PRP KITS

For the activation of platelet, bovine thrombin is employed which can raise immunogenicity and may cause immune reactions and carries a threat of transmission of bovine viral infection to humans.
The after care in PRP is similar to GFC. It is important to avoid touching or combing the treatment area. Also, avoiding the indulgence in perspiration inducing activities.
The topical and oral medicines can be applied as per the recommendation of the treating doctor.

Contraindications

The contraindications of PRP and GFC are similar. The absolute contraindications are thrombocytopenia, platelet dysfunction, sepsis, local site infection, hemodynamic instability, anticoagulation therapy, hypofibrogenemia and chronic liver disease.

Conclusion

With advent of GFC monotherapy remarkable improvement was noted in several indications. However, further confirmation in larger randomized controlled studies is warranted.
Overall, it is well tolerated. Thus, GFC therapy can be a safe, effective, and new option in the armamentarium of several indications.

Criteria	PRP	GFC
Prepared from patient's blood	Yes	Yes
Final outcome	Platelets with some essential cells	High concentration of growth factors derived from platelet activation
Centrifugation	It is the first step to initiate separation	Post platelet activation No platelet loss
Platelet loss	Yes	No
Complexity of procedure	Yes	No
Operator dependence	Yes	no
Output stable	Immediate use	Can be left at room temperature for 8 hours at 4 degree Celsius
Results	Takes longer time and variable	Optimum and takes less time
Number of sessions needed	More	Less
Pain and inflammation	Moderate	Very less chance
Risk of infection	Present	Completely sterile

Table 1: Differences between PRP AND GFC modified PRP

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NEWER PEELS IN DERMATOLOGY

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Peels have become an integral part of every aesthetic practice. These are easy to learn and perform and no special set up is needed. Also, the safety and efficacy has been established over years. Peels are being used as a treatment modality for a number of dermatological conditions like acne vulgaris, post acne scarring, melasma, post inflammatory hyperpigmentation and lichen planus pigmentosus. Use of peels for enhancement and improvement of skin texture and tone is increasing by the day. Peels are being used as a part of medi-facials also.

The conventional peels like glycolic acid (alpha hydroxyacids-AHA), salicylic acid (beta hydroxyacids-BHA) and tricholoroacetic acid (TCA) have stood the test of time. When used for pure aesthetic conditions, no downtime is acceptable. For dermal pigmentation, medium depth peels are recommended but these are associated with a significant risk of post inflammatory hyperpigmentation in dark skin types. Advancement in science and technology has led to better formulations.

Modified AHAs/ BHAs : These are now available in gel base where the active ingredient is released slowly – hence these can be safely used in patients with sensitive skin.

Modified phenol peels: Phenol is the oldest peeling agent but its use in darker skin types was never approved due to the high risk of post inflammatory hyperpigmentation. Now a unique mixed blend of phenol, TCA, retinoic acid, phytic acid and a mixture of hydroxy acids glycolic acid, salicylic acid, ascorbic acid and mandelic acid are available. Such combinations make the conventional agents safe for use in all skin types.

Combination Peels: Dermatologists are now opting for combination of two different peels in same sitting rather than increasing the concentration of one. Salicylic acid peels can be used for oil control and increasing the penetration of the glycolic peel, used subsequently. In this approach, a 35% GA would give results like a medium depth peel without increasing any chances of side effects. Salicylic acid peels are used with other peeling agents to increase the depth of penetration.

Yellow peel: A priming agent containing tartaric acid, citric acid in aqueous base is used followed by a retinol mix in a cream base. This is left on the skin for 6-8 hours.

Body Peels: Peels are now being increasingly used for body parts other than face. Body peels are being done for pigmentation due to macular amyloidosis, post inflammatory hyperpigmentation, body acne and for general improvement in texture, tone and tan removal. On body, higher percentage of active ingredient is used for longer duration of time to ensure deeper penetration, since the skin here is thicker than face. In case of any adverse effect like crusting, the healing is slower and unpredictable because of less appendageal

structures, hence careful supervision is recommended.

There is a risk of systemic absorption, hence care has to be taken of the total area on which peeling agent is used in one session. Salicylic acid gets readily absorbed through skin. Hence, it should not be applied over more than 50 % BSA in one sitting. Phenol peels can cause cardiac, hepatic and renal side effects hence, these should be used with caution on body.

Eye Peels: Peels are being increasingly used to address the problem of pigmentation around eyes. Mild peels are recommended over this area. Mandelic, arginine, kojic, lactic peels are used, besides the conventional glycolic peels can be used as eye peels. Liposomal peel preparations are preferred due to the high safety margin.

Lip Peels: Alphahydroxyacid and beta hydroxyacid peels and alpha arbutin are being used over lips to decrease pigmentation and stimulate collagen synthesis and improve fullness. In skin types I-III even phenol peels and TCA peels have been used. Peel is applied only on the vermilion part. Salicylic acid peel is avoided due to risk of systemic penetration. The patients are advised to moisturize the lips in between sessions and avoid lipsticks for at least 24 hours following a superficial peel.

Nail peels: Medium depth peels have been found useful for superficial nail abnormalities like trachyonychia, pitting and ridging. Superficial peels like glycolic acid 35 % have been used for brittle nails. Peels have also been tried as a treatment modality for onychomycosis.

Combination of peels with other resurfacing procedures

For optimum results in conditions like acne scarring and dermal pigmentation peels are combined with other procedures like microneedling, radiofrequency and lasers. For superficial peels, a gap of 1 week is enough but for medium depth peels a gap of 2 weeks is recommended. The gap between sessions can be increased or decreased, depending on the discretion of the treating dermatologist.

Peels during pregnancy

Salicylic acid is a Category C drug, hence has to be avoided during pregnancy.
AHAs are category B drugs – can be used safely.

Peels at Home
With the increasing popularity of peels, home use by patients is also on the rise. To make these peels especially safe and easy to use, few innovations have been made. The key ones are:

- pH adjusted peels: Conventional peels have low pH hence increased chances of causing skin irritation. Now a range of pH adjusted peels are available which give results without causing irritation or sensitivity. Hence better results can be achieved with minimal chances of side effects. pH buffered glycolic peels (upto 30 %) are recommended for home use. The result is weaker than the non-buffered peels but these are extremely safe.

- mproved Technology (Timed release preparations)

Peels with time release preparation, ensure controlled and uniform release of the peeling agent hence avoiding any hot spots and subsequent crusting and chances of post inflammatory hyperpigmentation. These are precise, tailored and safe. Peeling agents like glycolic acid and retinol in time release preparations are suggested for home use. These are mostly kept for a long time over the skin.

Now there is a better understanding among the dermatologist regarding the need for skin barrier protection in patients undergoing peel procedures. Besides, detailed instructions regarding the pre and post peel care, patient is advised to use a mild cleanser, moisturizer and regular use of sunscreen. Peels have now become a versatile tool to improve normal skin and a number of stubborn skin conditions with minimal downtime. New technology is being used for peels, different bases are being tried and new molecules are being introduced, to increase effectiveness, increase patient comfort and decrease downtime.

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EXOSOME MESOTHERAPY: A NEW FRONTIER IN DERMATOLOGY

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In the ever-evolving landscape of aesthetic medicine, researchers and practitioners are constantly exploring innovative approaches to address the diverse needs of patients seeking rejuvenation and enhancement. One such promising avenue that has garnered attention in recent years is exosome mesotherapy. This novel technique combines the regenerative potential of exosomes with the precision of mesotherapy to offer a natural and minimally invasive solution for skin rejuvenation, scar reduction, and hair restoration.

Introduction to Exosomes and Mesotherapy

To understand the concept of exosome mesotherapy, it is essential to delve into the fundamental components involved. Exosomes, small extracellular vesicles released by cells, play a crucial role in intercellular communication and tissue regeneration. Laden with proteins, lipids, RNA, and other bioactive molecules, exosomes have emerged as key players in promoting cellular repair and regeneration processes.[1]

Mesotherapy, on the other hand, is a well-established technique in aesthetic medicine that involves the injection of small amounts of medications, vitamins, minerals, and amino acids directly into the mesoderm, the middle layer of the skin. This targeted delivery enables the effective administration of therapeutic agents to address various cosmetic concerns, including skin aging, fat reduction, and hair loss.

The Concept of Exosome Mesotherapy

Exosome mesotherapy represents a synergy between these two concepts, harnessing the regenerative potential of exosomes derived from stem cells and the precision of mesotherapy delivery. By isolating exosomes from stem cell cultures and incorporating them into mesotherapy, dermatologists aim to capitalize on the reparative properties of exosomes to promote tissue regeneration and rejuvenation.

The rationale behind exosome mesotherapy lies in the ability of exosomes to modulate cellular processes involved in wound healing, collagen synthesis, and overall skin health. By delivering exosomes directly to the target tissue via mesotherapy, practitioners seek to stimulate the skin's intrinsic repair mechanisms and enhance its natural rejuvenation capacity.

Scientific Basis and Mechanism of Action

The scientific underpinnings of exosome mesotherapy stem from a growing body of research supporting the role of exosomes in regenerative medicine.[2] Studies have demonstrated that exosomes can exert a range of effects on recipient cells, including promoting cell proliferation, enhancing tissue repair, and modulating inflammatory responses.[3]

At the molecular level, exosomes mediate their effects through the transfer of bioactive molecules, such as growth factors, cytokines, and nucleic acids, to recipient cells. These cargo molecules can influence various cellular processes, such as gene expression, protein synthesis, and signaling pathways, ultimately leading to tissue regeneration and repair.

Applications and Benefits

Exosome mesotherapy holds promise for a wide range of aesthetic applications, including:

- **Skin rejuvenation:** By stimulating collagen production and enhancing skin elasticity, exosome mesotherapy can help improve skin texture, tone, and overall appearance.[4]

- **Scar reduction:** Exosomes have been shown to promote wound healing and tissue regeneration, making them potentially effective in reducing the appearance of scars and blemishes.[5]

- **Hair restoration:** Exosomes derived from stem cells may stimulate hair follicle growth and improve hair thickness and density, offering a non-invasive option for addressing hair loss.[1]

One of the key benefits of exosome mesotherapy is its minimally invasive nature. Unlike surgical procedures or aggressive treatments, exosome mesotherapy involves targeted injections or topical application of exosomes after microneedling/laser therapy that minimize trauma to the skin and reduce downtime for patients. Additionally, exosome mesotherapy offers a natural approach, harnessing the body's own regenerative mechanisms to achieve cosmetic improvements.

Clinical Evidence and Studies

While exosome mesotherapy shows promise in theory, clinical evidence supporting its efficacy and safety in aesthetic applications is still emerging. Preliminary studies and case reports have reported encouraging results, including improvements in skin texture, reduction in wrinkles, and enhanced hair growth following exosome mesotherapy treatments.[1-5]

However, more rigorous clinical trials are needed to validate these findings and establish the optimal protocols for exosome mesotherapy. Factors such as exosome source, dosage, injection technique, and treatment frequency require further investigation to optimize treatment outcomes and ensure patient safety.

Safety Considerations and Side Effects

As with any aesthetic procedure, safety considerations are paramount in exosome mesotherapy. While exosomes derived from stem cells are generally considered safe, potential risks and side effects may include injection site reactions, allergic reactions, and infection. It is essential for practitioners to conduct thorough evaluations, educate patients about potential risks, and adhere to strict sterile techniques to minimize complications.

Cost and Accessibility

The cost of exosome mesotherapy may vary depending on factors such as the provider's expertise, geographic location, and the specific treatment protocol. While exosome-based therapies may represent a higher upfront investment compared to traditional mesotherapy or other aesthetic procedures, some patients may find the potential long-term benefits and natural approach worthwhile.

Future Directions and Challenges

Looking ahead, exosome mesotherapy holds promise as a cutting-edge approach in aesthetic medicine. Continued research and innovation are needed to optimize treatment protocols, expand the range of applications, and address remaining challenges, such as regulatory considerations and standardization of exosome products.

By leveraging the regenerative potential of exosomes and the precision of mesotherapy delivery, exosome mesotherapy offers a promising avenue for achieving natural and long-lasting cosmetic improvements. As the field continues to evolve, exosome mesotherapy may emerge as a cornerstone of modern aesthetic practice, empowering patients to enhance their beauty and confidence through the power of regenerative medicine.

In conclusion, exosome mesotherapy represents a new frontier in aesthetic medicine, offering a unique blend of science, innovation, and natural rejuvenation. While further research and clinical validation are needed, the potential benefits of exosome mesotherapy are undeniable, paving the way for a brighter future in cosmetic enhancement and rejuvenation.

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PHOTOQUIZ

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History

A 16-year-old male born out of non-consanguineous marriage presented with thickening of skin on both palms and soles since one year of age and hyperkeratotic lesions on dorsum of hands which developed a few years ago. He also had hearing loss since childhood. No other family members had similar findings.

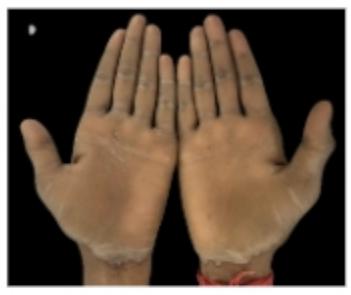


Figure 1. Diffuse, transgredient palmar hyperkeratosis

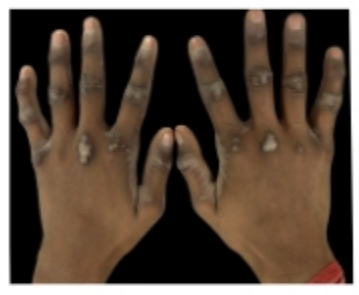


Figure 2. Hyperkeratotic plaques on knuckles and dorsae of hands

Examination

Cutaneous examination showed transgredient, diffuse palmoplantar hyperkeratosis [Figure 1], starfish shaped hyperkeratotic plaques on knuckles and dorsum of hands [Figure 2]. There were no constriction

bands or ichthyosiform dermatosis. Hair, teeth, and nail examination was normal. He had sensorineural hearing loss. Rest of the systemic examination was normal.

What is the diagnosis?
Vohwinkel syndrome

Discussion
Vohwinkel syndrome is a rare autosomal dominant palmoplantar keratoderma. It occurs due to mutation in GJB2 which encodes connexin 26. Connexin 26 is expressed in in palmoplantar epidermis and sweat glands. Dominant negative or gain-of-function effects may be involved in the pathogenesis of cutaneous manifestations. It is also expressed in the cochlea where it may permit the recycling of potassium to endolymph.

The disease begins in childhood as shiny/ translucent papular hyperkeratosis which become confluent on hands and feet and is often referred to as having honeycomb pattern. The diagnostic features of Vohwinkel syndrome include star fish shaped palmoplantar hyperkeratosis, constriction bands of the digits (pseudo ainhum) leading to auto amputation, starfish shaped keratotic lesions, salmon-colored or articular cushion on dorsum of hands.

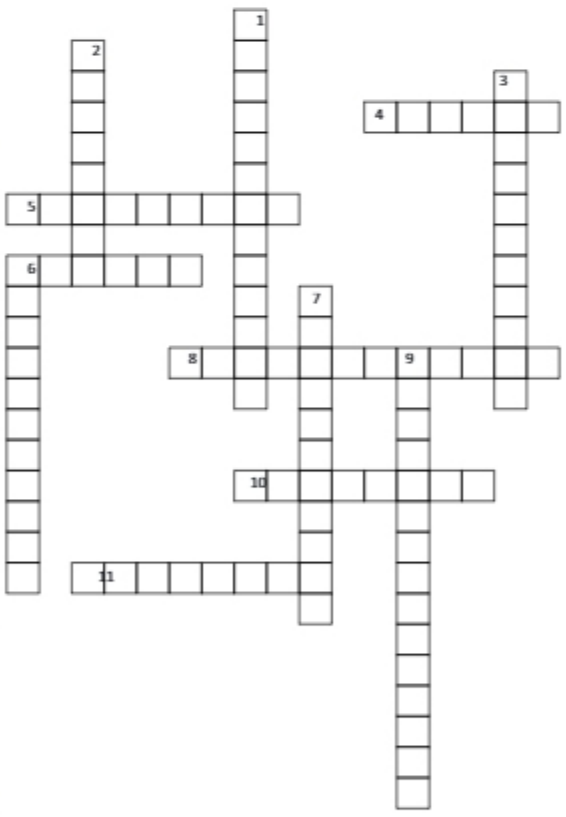
The disease is classified into two variants: ichthyosis associated variant (Camisa's variant associated with loricrin mutation) and deafness associated variant. Hearing loss is non progressive and is often not appreciated until infancy. It can be associated with nail dystrophy, scarring alopecia, neurological abnormalities.

Diagnosis is clinical. Audiometry is indicated to evaluate the extent and nature of hearing loss. Histopathological findings are non-specific. Genetic testing when available can be done.
Treatment is difficult and symptomatic. Mechanical debridement, use of keratolytics (urea, lactic acid, salicylic acid containing topicals) under occlusion and oral retinoids are helpful. Another aim of treatment is releasing constriction bands.

Early screening for hearing impairments and appropriate rehabilitation (hearing aids, speech therapy, language training, cochlear implantation, educational programmes) for the hearing loss are important. Differential diagnosis includes other variants of PPK with hearing loss and other mutilating PPKs.

CROSSWORD

Dr. ABHINAV BANSAL
PG Resident, Department of Dermatology,
ABVIMS & DR RML Hospital



Across

4. 1st anti-leprosy vaccine developed by American leprosy mission
5. FDA approved drug for Actinic keratosis, Basal cell carcinoma and genital warts
6. 3 minute sweat control patch FDA approved for axillary hyperhidrosis
8. Upcoming new oral single dose antibiotic for treatment of uncomplicated gonorrhea
10. FDA approved vaccine for the prevention of shingles in people more than 50 years age
11. Contact allergen of the year 2024

Down

1. 1st oral azole anti-fungal approved for the treatment and prevention of recurrent vulvovaginal candidiasis
2. 1st hyaluronic acid intradermal microdroplet injection approved for enhancing skin smoothness
3. Substance secreted by blister beetles approved for treatment of molluscum contagiosum in children above 2 years age.
6. First and only IL17A and IL17F inhibitor approved for the treatment of moderate-severe plaque psoriasis
7. Topical PDE4 inhibitor approved for seborrheic dermatitis in 0.3% foam preparation
9. Only selective TYK2 inhibitor which is approved for treatment of moderate-severe plaque psoriasis in adults

EVENTS IN THE SECOND QUARTER (APRIL- JUNE) OF 2024

OUR TEAM TAKES OVER

Carrying on the legacy of those who have come before us is a weighty responsibility.

Our team took over the office of IADVL-DSB in April, 2024 and we hope to maintain the extraordinary pace kept by the previous teams and will strive to take the association to greater heights!

WORLD SKIN HEALTH DAY

Was enthusiastically celebrated on April 6, 2024 by our branch members.

Private practitioners as well as residents in various government hospitals across Delhi displayed posters educating general public about importance of visiting a qualified dermatologist.

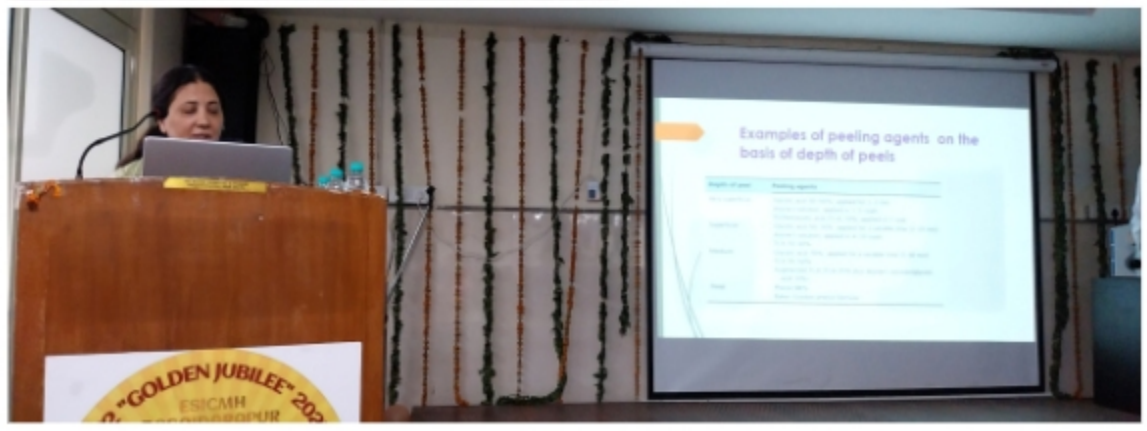
IADVL DSB team used this opportunity to create community awareness at Janpath market where we focused on educating general public regarding saying NO to self-medication & stopping misuse of steroids and visiting a qualified skin specialist for their skin health concerns.

1ST MONTHLY MEET AT BASE HOSPITAL

The 1st monthly meet was held at Base Hospital on April 20, 2024 and was organized by Dr Shailendra Shrivastava & his team. Around 65 delegates attended the meeting.

2ND MONTHLY MEET AT ESI BASAIDARAPUR

Our second monthly meet was held at ESI Hospital, Basaidarapur and was organized by Dr Ragunatha Shivanna & his department. The meeting was attended by 55 delegates.



VIDEO COMPETITION BY POSTGRADUATE RESIDENTS

On World Skin Health Day, postgraduate residents in various government hospitals in Delhi helped in spreading awareness about skin diseases among patients.
The team DSB organized a competition in which postgraduate residents had to share a video spreading awareness. The first prize was won by residents of Safdarjung Hospital and second was won by resident of RML Hospital.

IADVL-GWR PLEDGE ACTIVITY- MOVIE SCREENING

We proudly announce that IADVL has successfully made a Guinness world record on 5th-6th May, 2024 in order to create awareness among public about importance of consulting a qualified dermatologist. To join the cause, we held a special movie screening on 5th May and displayed QR codes at venue for facilitating the pledge-taking.

CME ON ATOPIC DERMATITIS

IADVL DSB team organised a CME on atopic dermatitis where emphasis was laid on the systemic management of the disease.
It was also at this event that abrocitinib was launched by a pharma company (Glenmark pharma) for use in patients with atopic dermatitis.

GWR CERTIFICATE AWARD CEREMONY

IADVL is proud to announce that it has set a new Guinness World Record for the highest number of pledges for dermatological disease awareness in a 24-hour period.
The record-setting campaign took place on May 5–6, 2024, and garnered an astounding 9405 pledges from doctors across the country. The official declaration came up on May 18, 2024, at the IADVL headquarters in Delhi. Dr. Manjunath Shenoy, National IADVL President and Dr. Bhumesh Kumar Katakam, National Honorary Secretary were also present on the occasion.

IADVL DSB IN NEWS

Medgate Today, 7th May

आईएडीवीएल ने की त्वचा रोग संबंधी जागरूकता बढ़ाने की पहल

Veer Arjun - 5th May

Pharma Biz, 7th May

आईएडीवीएल ने की त्वचा रोग संबंधी जागरूकता बढ़ाने की पहल
गिनीज वर्ल्ड रिकॉर्ड के लिए आज और कल होगा आयोजन

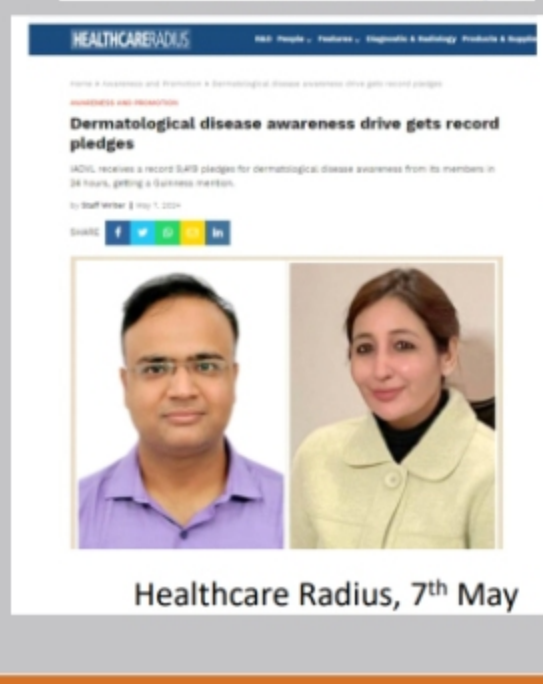
Amrit India- 5th May

• Dainik Bhaskar- 7th May

आईएडीवीएल ने की त्वचा रोग संबंधी जागरूकता बढ़ाने की पहल

• Dainik Bhaskar- 5th May

Indiaeducation, 7th May



Healthcare Radius, 7th May

APN News 5th May

DVL WELFARE TRUST: OUR OWN SCHEME FOR OUR OWN BENEFIT!

DR. CHANDER GROVER, MD, DNB, MNAMS
Professor, Department of Dermatology and STD
University College of Medical Sciences & GTBH. DELHI;
DVL Welfare Trust Coordinator, IADVL-DSB 2024

DVL Welfare Trust is a unique welfare scheme, initiated by IADVLites, which works for IADVLites. It is targeted at IADVL Life Members & their family. Overall, it is an affordable & accountable scheme, which has proven to be a dependable companion in crisis for our fraternity.

The motto of DVL Welfare Trust is "Help yourself, Help others" and that is the true spirit and design of the scheme, where we IADVL members choose to invest small amounts of money per year to help us as well as our dermatologist colleagues, in the long-term. Keeping this in mind, EVERY ELIGIBLE MEMBER of IADVL, the young and the old, are called upon to enroll through nominal payments, which go a long way in fostering our unity and sense of purpose, apart from securing our own future.

The trust is going strong with 1050 members, as of April, 2024. This is a strong network of members, which strengthens the social security net for all the beneficiaries. The trust was registered at Vadodara, Gujrat in 2011, vide registration no. F/2788/Vadodara. The aim of the trust is to provide financial assistance to the family, in the event of member's death. It also provides comprehensive indemnity cover (upto a maximum amount of 15 lakhs) in the event of litigant situations during the discharge of professional duties of the members. Member benefits increase as the number of Trust members increases. The benefits to the member will continue till death, even though the payments stop after 30 years (for the IADVL Member) or 40 years (for the spouse or children). The profit of the trust remains with us, and can be redistributed among members in the form of various benefits. The trust also aims to educate the members (including clinic, & subordinate staff of the member) to prevent any litigant situation. It also guides them regarding how to deal with litigation, in the event of such a situation.

How do I join DVL Welfare Trust?

IADVL LM can apply and join DVL Welfare Trust by paying Admission Fee (One time, decided as per age) along with advance fraternity contribution (Rs. 2500 initially). The spouse and the children are also eligible to join with payment. The annual membership fee is Rs. 750 (hiked by Rs. 50, every 5 years). If the member chooses to apply for professional Indemnity, the fee is decided as per type of practice (details available on website). Annual legal fee is paid by regular members, depending on the the indemnity coverage (Rs. 1,000 or Rs. 3,000 as per the type of practice). In addition, members pay Death Fund Contribution (DFC) at Rs. 500 per death in the year. The payment system is very user-friendly as payments can be made through cheques, drafts, NEFT, Net banking, Credit or Debit cards by online payment through the website (www.dvlwelfaretrust.org). No dealings are done in Cash.

Benefits offered by DVL Welfare Trust

The scheme offers Social security to its members, and the benefits start ONE year after joining. Upon death of any members, the designated nominee will get monetary help in terms of Rs. 450/- x No. of members. Thus, it is clear that the higher are the numbers of members, higher is the benefit. This is also one way of helping our dermatologist colleagues' family in times of stress. This social security scheme is thus not comparable to any Term Insurance Plan.

The Professional security offered by the scheme covers individual members opting for it. The trust extends its help in all types of cases (civil, criminal, labour, consumer redressal fora, disputes arising out of clinical establishment act, etc.). It also offers educative seminars for its members, which are useful in preventing litigation. The professional indemnity is provided through Legal MD Global Consulting Services Pvt. Ltd. It provides comprehensive risk management services to individuals including coverage for cosmetic procedures, facility for medical centre and unqualified staff coverage (available with additional premium). In addition to the medico-legal support, it also offers weekly medico-legal tips (through SMS), monthly newsletter on medico-legal crisis management support, online medico-legal compliance & audit of practice, and other legal (civil & criminal) support from the legal team. Through the professional protection scheme, the trust helps drafting of legal replies through medico-legal experts. This prevents exploitation by other schemes through periodic hikes in premium of other schemes. It places a vast databank and years of experience in handling medico-legal cases, at the members' disposal.

In contrast, standard professional insurance schemes stay dependent on advocates, introduce periodic hikes depending upon the number of cases and compensation awarded, have limited experience and knowledge in handling medico-legal cases, prefer off-court settlements, asking doctor to confess negligence, and are not bothered about the interest of the profession.

To summarise, DVL welfare trust offers the advantages of very low premiums, and assurance that surplus amount is utilized for members only. Benefits to all members increases with an increase in the membership. Spouses are allowed to join the scheme. It offers the advantage of professional Indemnity. As it is our own scheme, we can expect periodic modifications and improvement, to make it more member friendly from time to time.

Join DVL Welfare Trust TODAY! And make your contribution towards the fraternity! You can access all details at www.dvlwelfaretrust.org or www.iadvl.org. Please feel free to post your queries at dvlwelfaretrust@gmail.com. Better still, you can contact the Chairman, Dr Chetan Patel (9426378078, drcnpatel@gmail.com) or the Vice-Chairman, Dr Vineet Relhan (9910086636, vineetrelhan@gmail.com) and resolve your queries with authentic responses.

Be a member of your own
DVL WELFARE TRUST
BY **IADVL** • OF **IADVL** • FOR **IADVL**

1050+ MEMBERS

JOINED DVL WELFARE TRUST
(RELIABLE PARTNER IN CRISES)

Would you like to be a part of our family?
we will help you...

HELP IADVL TO HELP YOU

Benefits:

FOR SOCIAL SECURITY

Benefits start after ONE year of joining as a member.
Nominee of the member will get help in terms of money Rs. 450/-XN (N is no. of members) the more the members the more the benefits.

PROFESSIONAL INDEMNITY

Rs 1000 to 3000 as annual premium depending on the type of practice.
Rs 15 lac coverage per year

Scan QR Code to join
DVL WELFARE TRUST

DVL WELFARE TRUST

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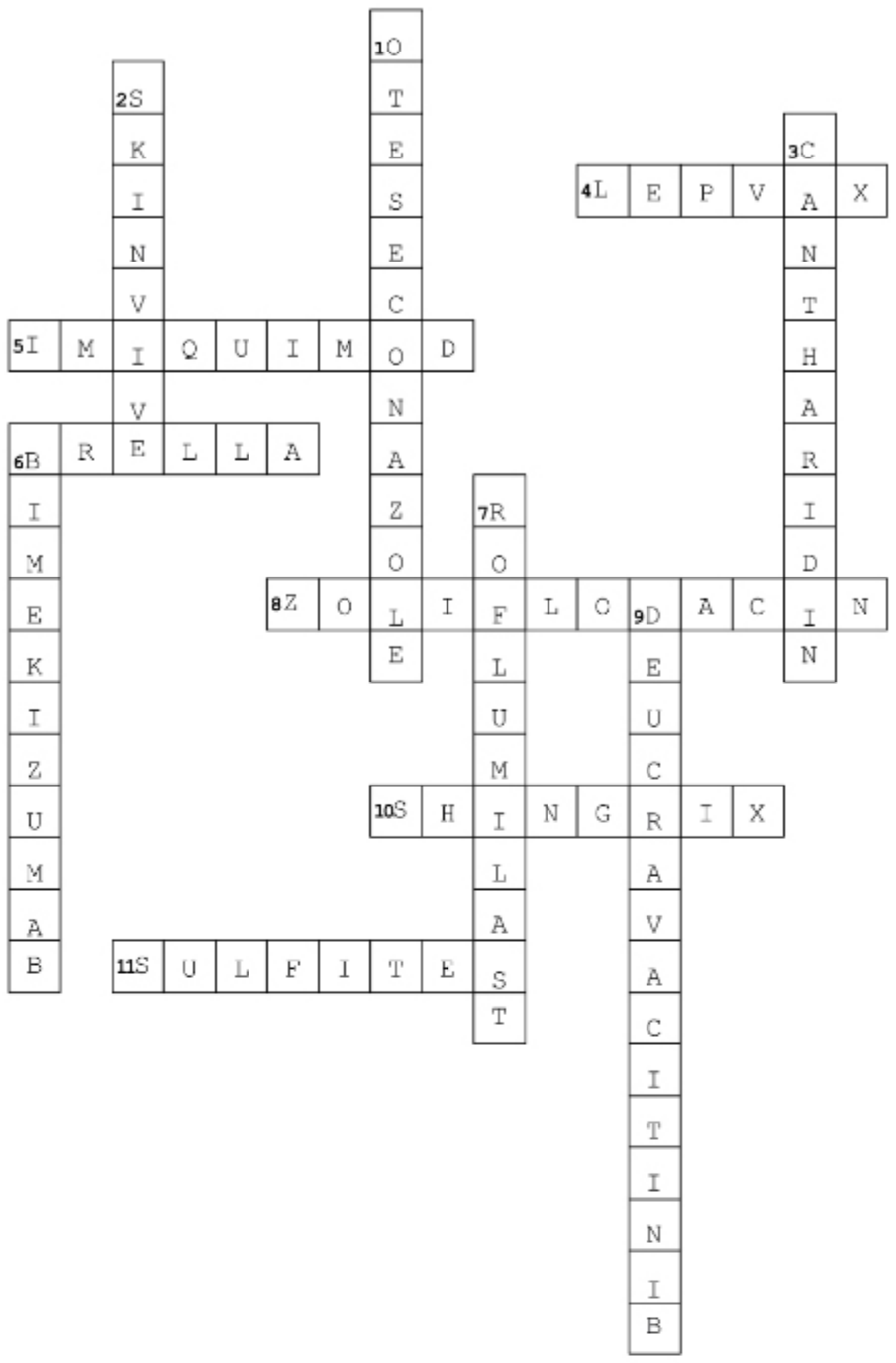
SOLUTION TO THE CROSSWORD



UPCOMING EVENTS

- MAMC MONTHLY MEET (JULY, 2024)
- AIIMS MONTHLY MEET (AUGUST, 2024)
- DERMA VYAKHYA (A web series of clinical and aesthetic case discussions, meant for all practitioners)
- CME on photoprotection in melasma- 16 June 2024
- Dermazone North- 4-6 October, 2024

HOW TO REGISTER FOR E-VOTING?

The link for registration for E-voting is ther on the homepage of IADVL website.
For any assistance, contact Ms Heena (IADVL HQ) + 91-78380 13829

INVITING ARTICLES

Those who are interested in publishing their articles in the next issues of IADVL-DSB newsletter can mail them to: **dr_shikhaarora@yahoo.co.in**

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5 Chemical Filters

7 Bio Molecules

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Light Weight

Water Resistant

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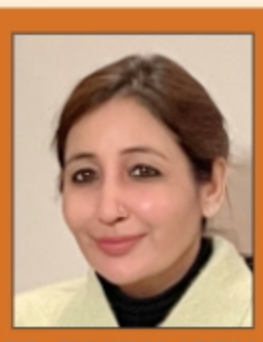
DERM-CONNECT
INDIAN ASSOCIATION OF DERMATOLOGISTS, VENEREOLOGISTS AND LEPROLOGISTS (DELHI STATE BRANCH)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