DERM-CONNECT

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

NEWSLETTER : JULY - DECEMBER 2025 VOLUME 2 ISSUE 3

THEME:

UPDATE IN PROCEDURAL DERMATOLOGY

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Table of Contents

Message from

Dr.Deepika Pandhi
President
IADVL-Delhi State Branch 2025-26

Dear Colleagues, it gives me great pleasure to present the 3rd issue of **IADVL Delhi state Branch newsletter for 2025.** We have strived with your support to focus on diverse activities, including novel academic activities, anti-quackery efforts, community related activities to strengthen our specialty of Dermatology and social events to strengthen our IADVLite bonding!

Academics:

The effort is to hold academic activities that will aid our colleagues cutting across place of practice, academic institution or private practice, and encourage greater participation. With the aim of skill development we held innovative programs this year, like the first ever STI and genital dermatoses-video based clinical and diagnostic workshop that was held on 28th September. It was a huge success with attendees from across India and with a clinic-microbiological video-based demonstration of a medley of STI examination, diagnosis and treatment and case-based panel discussions including management in private practice. There were e poster competition and quiz, that had active participation. Collaborative events included Dermatopathology Workshop on 27th-28th July at AIIMS , New Delhi with SIG Dermatopathology (IADVL Academy) and Dermatopathology Society of India, with a unique clinic-pathological correlation approach; PGPDT, a zonal postgraduate, video based training workshop (with live streaming and discussion) that included hands on suture training workshop, was held with SIG Dermatosurgery (IADVL Academy) and AIIMS New Delhi on 11th and 12th October at AIIMS, New Delhi. It was well attended with enthusiastic participation. A CME on Hidradenitis Suppurative- A multimodal approach with SIG Acne and appendageal diseases (IADVL Academy) was also held on 30th November with in depth discussion and a lot of audience participation and interest.

The second and third monthly meetings were held at LHMC on 30th August, 2025 and at AIIMS, New Delhi on 27th September 2025 with discussion of excellent cases. In addition, 2 more editions of Relay Quiz and a new 'Ask the expert Session' were held, with the latter having open discussion on a chosen topic-the first speaker being Maj Gen Manas Chatterjee on - Challenging cases in Dermatosurgery and Dr Chander Grover was the expert faculty at AIIMS for the session on Nail disorders- diagnostic and therapeutic approach. Watch out for the grand cumulative prize for Relay Quiz winners during CUTICON (The winners are announced in the newsletter).

The IADVL DSB CUTICON on 7.12.2025, for the first time is preceded by 9 workshops, including 3 D injectable training workshops. The response has been amazing with participation from DSB members and beyond. We now plan to round off the year with focused postgraduate event- IADVL Delhi state Branch Postgraduate clinic on 29th March 2026. Mark your calendar for this one day event! With a focus on our younger colleagues, we had initiated the IADVL DSB Post Graduate Thesis Grant 2025, an initiative aimed at supporting dermatology post graduate students across Delhi for carrying out their thesis research. A total of 2 grants of Rs 75,000 each will be awarded. (The names of the winners are announced in the newsletter).

Further, the IADVL DSB official Newsletter 'Derm-Connect, the 3rd quarter edition (April to June) was published and is being released during the IADVL DSB CUTICON. The theme of the newsletter is on Updates in Procedural dermatology in line with theme of CUTICON- "Hot Topics in dermatology practice and patient care". The newsletter contains interesting articles updating the busy practitioner and post graduates on science behind what is trending in dermatosurgery these days. The 4th edition of the newsletter is currently in process- we would love to have your submissions for the same. Under the Aegis of IADVL DSB, a landmark 5 volume book series 'Compendium of Diagnostic Dermatology' with a focus exclusively on diagnostic aspects of dermatological diseases is being released.

Continue.... Next Page

Social activities

Community:

To continue our efforts to contribute our services to the vulnerable population, we held a screening and dermatology health camp on 22 nd November, 2025 from 1.30-4.30 pm at Sewa Bharti Sewa Dham Vidya Mandir Residential School, Delhi. Amongst the 418 inmates and staff of this residential school for boys (orphans or those whose parent is/are unable to provide for them), approximately 300 were screened, prescriptions were given and medicines distributed by a team of 10 IADVL DSB dermatologists. Additionally, educational activities with patients and their attendants were carried out about basic skin hygiene, common skincare myths and pitfalls, and the dangers of self-treating skin conditions and need of consulting only a dermatologist for skin, hair and nail disease were highlighted. We have been holding focused campaigns like the patient education initiative campaign to mark the World Eczema Day on 14 th September with the theme being - "Our Skin, Our Journey. **Patient education material on 1. What is Eczema; 2. Eczema and Associations; 3. Eczema and Stress were prepared.** IADVL-DSB World Psoriasis Day Video Contest was held with the submission of 3-minute videos (song, poem, role-play, story, etc.) in line with the -Theme of World Psoriasis Day 2025- Psoriatic Disease and Comorbidities: Understanding the Domino Effect! The names of the winners appear in this newsletter.

In the Pre-conference workshop, we have also collaborated with FUE Asia for Project HOPE **Hair Outreach for Patient Empowerment -A global charitable initiative for patients with secondary cicatricial alopecia.**

If, any of our members wish to hold community activities, please reach out to us at contact@iadvldelhi.com.

IADVL members:

For the first time we held the IADVL DSB Cricket league between 4 zones on 26th October. The matches were keenly contested and the West Warriors emerged as the winners. We have also planned a IADVL DSB CUTICON dinner on 6th March with Talent fiesta- IADVL DSB Idol, Super dancer and Laughter champion. Mark your calendar for the upcoming picnic on 18th January,2026. Come celebrate being together with your IADVL family and also join for the IADVL DSB annual dinner on 14th March 2026.

Please also stay connected with IADVL DSB through the website and our social media handles.

Anti- Quackery

We have been actively processing complaints received. We **prepared multiple videos including messages from the members of the IADVL Delhi State Branch, as part of our public awareness campaign against Quackery-Raise Awareness! Restore Trust! And Reject Quackery! The message- "Consult only a NMC/ NBE certified Dermatologist for your skin, hair, genital and nail diseases."** There have been anti-quackery message selfie points at all our events. Please click selfies at all future events and post on your social media. Let us actively spread the message that only a qualified Dermatologist should be consulted for any skin, hair, nail and genital complaint/s.

Dermatology, including Venereology, Leprosy and Surgical and Aesthetic Dermatology, is one of the most challenging and satisfying specialty, especially due to the recent advances in this field and the advent of new diagnostic and therapeutic options. Let us delve into these exciting topics and update our knowledge this year. Our knowledge and skill are the best weapon against Quackery. We also hope to have active networking and interaction at upcoming academic and social events. Request you to actively participate, stay connected and strengthen our specialty and our Delhi State Branch.

Warm Regards

Dr.Deepika Pandhi

President

Message from

Dr Rahul Arora
Hon. Secretary
IADVL-Delhi State Branch 2025-26

Dear Esteemed Members of the IADVL DSB, It is a great privilege to address you through the pages of Derm-connect, the official Newsletter of IADVL DSB and our vital link to the pulsating developments within our association. As we dedicate this edition to the theme of Dermatosurgery, we celebrate a discipline that stands at the intersection of surgical precision, aesthetic artistry, and profound patient care.

Dermatosurgery is no longer merely an ancillary skill; it is a core pillar of modern dermatology.

It encompasses procedures that are curative, preventive, and life-enhancing—from dermatosurgeries and scar revision to vitiligo surgery, hair restoration, and intricate aesthetic procedures. The rapid evolution of technology, coupled with sophisticated techniques like flap surgeries and advanced laser applications, demands continuous learning and adherence to the highest standards of evidence-based practice.

Over the past year, the IADVL DSB has focused intensively on strengthening the foundations of surgical training for its memebers. Our initiatives have centered on more PG Procedural Dermatology training, conducting specialized hands-on workshops in our conferences, and developing comprehensive consensus guidelines on common procedures. These efforts are aimed at ensuring that every IADVL member practicing dermatosurgery has access to world-class knowledge and skill refinement, ultimately elevating the quality of care delivered to our patients. Looking ahead, our commitment remains twofold: to embrace innovation while upholding ethical rigor. We encourage all members to actively engage with the DSB—whether by contributing challenging case reports, participating in academic events, or helping to shape our future research agenda. Let us commit ourselves to mastering the subtle nuances of wound healing, perfecting the artistry of aesthetic correction, and championing patient safety above all else.

We thank the editorial team of Derm-connect for dedicating this edition to this dynamic and high-impact field. Your continued support is invaluable.

Dr Rahul Arora
Hon. Secretary
IADVL DSB 2025-2026

Editors Note

Dr Shikha Gupta
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Editor, Derm-Connect Newsletter

Greetings everyone!

It is an honor for me to be associated with Derm- Connect, the official newsletter of IADVL- Delhi State Branch- since its inception, for 3rd year in a row. To witness it flourishing with each issue, providing opportunities to its branch members to showcase their academic achievements and their other passions as well. We will continue highlighting the branch activities being conducted by the superb team this year, led by Dr Deepika Pandhi and Dr Rahul Arora. One of the highlights of these past few months has been the "Workshop on STI & Genital Dermatoses", a one of a kind video-based workshop, which connected the delegates via videos to the STI clinics. Also a lot of emphasis has been given on educating the public against quackery as well as on conducting awareness campaigns for eczema, psoriasis and urticaria- a part of public health initiative.
The Practitioners Conclave provided much needed information on practical aspects of management in the clinics; the PGPDT North zone workshop and the CME on Hidradenitis suppurativa were also well appreciated.
I hope to continue to learn and enjoy from each contribution in this project.
At the end, I would request our esteemed members to let us know if they are interested in contributing to the newsletter by providing articles or other tidbits or most importantly, their valuable feedback.
As the Japanese writer Ryunosuke Satoro said, "Individually, we are one drop. Together, we are an ocean."

With warm regards,

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Editor, Derm-Connect Newsletter

Editors Note

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Dear Esteemed Members,

It gives me great pleasure to introduce this new edition of our IADVL-DSB newsletter. Each issue is an opportunity to bring meaningful, practice-enhancing knowledge to our dermatology community, and this time we turn our focus to a dynamic and rapidly evolving domain — Dermatosurgery.

With continuous innovations in surgical techniques, devices, and patient aesthetic expectations, dermatosurgery has grown far beyond its earlier boundaries. In this edition, we highlight recent advances and practical insights that we hope will enrich your day-to-day clinical practice and add tangible value to patient care.

A publication like this is only as strong as the collective behind it. Our sincere gratitude goes to our contributing authors for their time, expertise, and commitment. And to our readers — your engagement, feedback, and encouragement remain the true driving force behind every successful edition.

We hope this issue inspires learning, reflection, and renewed enthusiasm for the surgical arm of dermatology.

Warm regards,

Dr. Swati Agarwal
Editor, Derm-Connect 2025–26

INNOVATIONS IN DERMATOSURGERY

Intraoperative Onychoscopy A New Frontier in Nail Diagnostics

Dr Deepak Jakhar

Onychoscopy (dermoscopic examination of the nail unit) has become a vital tool in dermatology for non-invasive assessment of nail diseases. It helps evaluate nail plate, bed, folds, lunula, pigmentation, vascular changes, and so on, with greater clarity than naked-eye examination. However, some anatomical barriers—such as opacity or thickness of the nail plate—limit visualization of deeper structures (matrix, proximal bed) in many conditions. To address this, intraoperative onychoscopy (also called intraoperative dermoscopy of the nail unit) has been developed. This technique involves dermoscopic visualization of nail bed and matrix structures after avulsion or removal of the nail plate during surgery or biopsy. It allows direct, magnified assessment of structures that are otherwise hidden, helping guide biopsies, delineate margins, and improve diagnostic accuracy.

A recent systematic review (2024) has synthesized available studies on intraoperative onychoscopy, covering ~218 cases in 217 patients, across a spectrum of nail conditions.

Technique and Methodology

Equipment and Setup

- Use a dermatoscope capable of low-to-moderate magnification (e.g. ×10–50), preferably polarized mode to reduce glare and improve visualization of vascular and pigment features. Video dermatoscopes or digital USB dermatoscopes with image capture are helpful.
- For intraoperative procedure, once the nail plate is removed (partial or total avulsion or during biopsy), the exposed nail bed and nail matrix are directly visualized under intraoperative dermoscopy. Proper aseptic technique must be maintained (instrument sterilization, etc.).

Patient Selection

- Patients with suspicious pigmented longitudinal bands (melanonychia) where preoperative dermoscopy is equivocal, e.g., irregular width, color, positive Hutchinson sign, solitary nail, dystrophy.

- Conditions like suspected nail matrix neoplasms, subungual tumors (glomus), onychomatricoma, lichen planus, or when biopsy site needs precise selection.

Procedure

1. Preoperative dermoscopy of the nail plate: assess color, pattern of bands, presence of Hutchinson sign, irregularities.
2. Under local anesthesia and antisepsis, remove the nail plate (partial or complete) to expose nail bed and matrix if needed.

3. Apply dermatoscope (polarized or non-polarized mode) directly over the exposed bed/matrix. Sometimes interface medium is used, though in many intraoperative settings images are taken without medium.
4. Document images; examine patterns (pigment lines, dots, globules, structureless areas; vascular pattern; anatomical extent).
5. Correlate dermoscopic findings with histopathology after biopsy. Use the intraoperative view to pick the best biopsy site.

Findings: What Does Intraoperative Onychoscopy Reveal?

The systematic review (Slawinska et al., 2024) collected 19 studies with 218 cases, indicating intraoperative onychoscopy has been applied in a wide array of nail disorders: melanoma, nevi, hypermelanosis (melanocytic activation), melanocytic hyperplasia, melanophages, squamous cell carcinoma, glomus tumour, lichen planus, onychomatricoma, onychomycosis, subungual exostosis.

Some key disease-specific patterns:

- Melanonychia / Pigmented Bands: In a study of 20 patients (Kaur et al., 2020), intraoperative dermoscopy (IOD) of benign lesions (nevi, lichen planus) showed fine, parallel, regular bands localized to the proximal bed/matrix. In melanoma cases, there were dark, thick irregular bands, dots, globules, streaks, structureless areas.

- Subungual Epidermoid Inclusions (SEI): Recently reported (Theodosiou et al., 2025), intraoperative onychoscopy helped detect SEI structures (whitish dome-shaped projections on nail bed) during biopsy and reduced risk of inadequate specimen yield.

- Red lunula in Lichen Planus: Intraoperative onychoscopy plus histopathologic correlation showed that red lunula corresponds to capillary proliferation in proximal nail bed and matrix, helping assess severity.

Advantages

- nhanced visualization: direct view of matrix and bed allows features hidden under nail plate to be seen.
- Better biopsy targeting: helps select the most diagnostic area for incision/biopsy, reducing false-negatives.
- Margin delineation: for pigmented lesions or neoplasms, helps define how much tissue to include.
- Differential diagnosis: distinguishing benign from malignant melanonychia, fungal pigment vs melanocytic, or detecting subungual tumors.
- Potential reduction in unnecessary biopsies: in some benign cases, IOD findings may support surveillance rather than biopsy.

Limitations and Risks

- Evidence level: Many published reports are case series or small studies; high-quality controlled trials are lacking. The systematic review noted that most studies have low levels of evidence.
- urgical risk: Nail plate avulsion / biopsy carries risk of pain, infection, permanent nail dystrophy or scarring.
- Skill requirement: Surgeon/dermatologist must have dermoscopy experience, anatomical knowledge of nail matrix and bed, and capability to interpret intraoperative findings.
- Equipment logistics: Need for sterilizable dermatoscopes or disposables; ensuring good lighting, magnification, and image capture in operating field.
- Interpretation variability: Some features may overlap between benign and malignant conditions; dermoscopic features are not always definitive. Histology remains the gold standard.

Current Gaps & Research Needs

- Standardization of terminology: What is “irregular,” “structureless area,” “globule,” etc., needs consistent definition.
- Larger multicenter prospective studies to validate diagnostic accuracy (sensitivity, specificity) of IOD in melanoma and other serious nail conditions.
- Studies comparing IOD vs imaging (e.g., high-frequency ultrasound / reflectance confocal microscopy) for nail unit diagnostics.
- Assessment of cosmetic and functional outcomes of nail unit surgery guided by IOD.
- Cost-effectiveness analyses: whether IOD reduces total morbidity (by avoiding unnecessary biopsies or re-excisions).

Clinical Applications Practical Recommendations

Based on currently available literature, here are suggested best practice guidelines for using intraoperative onychoscopy:

1. Indications: Longitudinal pigmented bands suspicious for melanoma (irregular color/border/width, positive Hutchinson sign), tumor-like lesions (glomus, onychomatricoma), nail lichen planus with red lunula, subungual inclusions, or when preoperative dermoscopy is inconclusive.
2. Preoperative evaluation: Always perform preoperative dermoscopy of nail plate and folds; document dermoscopic features, take high-resolution photos. If these show benign features and remain stable over follow up, biopsy may not be urgent.
3. Consent and preparation: Discuss with patient risks of nail avulsion or biopsy (pain, nail dystrophy). Plan for anesthesia, sterile field, minimum required tissue.
4. Perform IOD during surgery: Once nail plate removed, use polarized dermoscopy (or appropriate mode) to examine matrix and bed. Identify suspicious pigmented areas (irregular bands/dots/globules), map out design for biopsy.
5. ample selection: Biopsy site should be chosen based on areas showing highest level of irregularity. If melanoma suspected, take full-thickness biopsy of matrix including nail bed.
6. Post-operative monitoring: Follow up for healing, nail regrowth; document cosmetic outcomes.

Conclusion

Intraoperative onychoscopy is emerging as a valuable adjunct in nail diagnostics—especially for challenging pigmented lesions where deep structures (matrix, nail bed) are involved. It enhances visualization, aids biopsy targeting, helps in differential diagnosis, and may reduce unnecessary surgery in benign conditions. However, it does not replace histopathology. Its utility depends on appropriate patient selection, surgical skill, and dermoscopy experience. More high-quality research is needed to standardize its use, validate its diagnostic accuracy, and quantify benefits versus risks.

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DERMATOSURGERY IN PEDIATRIC CASES - TIPS AND TRICKS

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Diagnostic and therapeutic procedures in pediatric care often generate significant fear and anxiety, which can persist into the postoperative period and negatively influence future pain experiences.[1] Children's memories of pain are especially vulnerable to distortion, and when recalled in a negatively biased way, they are linked to greater fear, distress, and heightened perception of pain later.[2] Anxiety strongly contributes to these biased pain memories and worsens perioperative outcomes, underscoring the need for interventions to reduce anxiety and improve children's experience of medical care.

Preoperative Preparation and Patient Assessment:

The foundation of successful pediatric dermatosurgery begins with thorough preoperative evaluation. Children require age appropriate communication, explaining procedures in terms they can understand while avoiding frightening terminology. Parents should be involved in discussions, but children must also be included to build trust and cooperation. A comprehensive medical history, including medication allergies and previous anesthetic experiences, is essential.

Preoperative skin preparation involves specific protocols for pediatric patients. Bathing with antiseptic soap the night before and morning of surgery reduces bacterial counts and infection risk. However, evidence suggests that chlorhexidine gluconate offers no significant advantage over regular soap in preventing surgical site infections.[3] The key is maintaining clean, intact skin barriers while avoiding harsh preparations that might irritate pediatric skin.

Anesthesia Considerations:

Local anesthesia remains the cornerstone for most pediatric dermatologic procedures. To reduce pain and anxiety, topical anesthetics such as EMLA cream should be applied in a thick layer under occlusion 60–90 minutes before the injection. Maximum dosing calculations based on body weight are crucial to prevent systemic toxicity, as children have increased risk due to their lower body weight.

Buffering lidocaine with sodium bicarbonate reduces injection pain by raising pH from approximately 4.3 to 7.4 in the standard ratio is 10:1 (1 part 8.4% sodium bicarbonate to 10 parts lidocaine with epinephrine.). Gentle skin manipulation before injection reduces pain perception. The slight pressure from skin tenting dampens nerve sensitivity while providing a reference point for children to understand the upcoming sensation. Always conceal needles and instruments until the moment of use, even when children know procedures are coming. This prevents anticipatory anxiety from escalating into uncontrollable fear responses. Offering videos, books, or games- and letting the child choose- maximizes its effect. Using cold packs and/or vibrating devices while injecting can also reduce the pain significantly. Triclofos, a phosphate ester of trichloroethanol, is an active metabolite of chloral hydrate used for pediatric sedation in a dosage of 40–100 mg/kg. Effectively, the peak of triclofos sodium is noticed in 40–60 min following administration.

Non-pharmacological approaches such as distraction techniques (watching favourite cartoons, playing mobile games, story telling) and hypnosis have been used to alleviate pediatric procedural anxiety. Hypnosis focuses attention, enhances coping mechanisms, and fosters

autonomy by guiding children away from distressing stimuli. It works through changes in higher brain centres, modulation of nociceptive signals, and the release of endogenous opioids like β-endorphins and enkephalins, which reduce pain transmission.

While most high-quality studies on hypnosis and pain have been conducted in adults, children, particularly those aged 7 to 14 are thought to be highly receptive due to their vivid imagination and creativity.[4] Hypnosis administered during anesthesia has been shown to reduce the required doses of analgesics both intraoperatively and postoperatively, thereby aiding in faster recovery.[5] This reduction in medication use is especially beneficial in pediatric patients, as it minimizes the risk of over-medication. It has demonstrated efficacy in reducing preoperative anxiety, postoperative distress, and procedural pain. Studies show hypnosis can shorten hospital stays, improve satisfaction, and sometimes serve as an alternative to pharmacological premedication or even general anesthesia in minor surgeries.[6] Techniques such as the "Magic Glove" provide rapid hypnoanalgesia, particularly for procedures like intravenous cannulation, though more research is still needed.[7] Hypnosis has long-term benefits as well. Posthypnotic suggestions and reinforcement during recovery can reduce postoperative pain and anxiety.[8]

Surgical Techniques and Wound Management:

Pediatric skin possesses unique healing properties with greater elasticity and faster regeneration compared to adult skin. This allows for larger excisions with primary closure and better cosmetic outcomes when procedures are performed early. However, the increased skin elasticity also predisposes to scar stretching, which is the most common complication in pediatric dermatosurgery.

Suture selection significantly impacts outcomes. Monofilament sutures cause less tissue reaction than multifilament materials. Consider using smaller caliber sutures and keeping knots small to minimize reactions.

Postoperative Care and Follow-up:

Wound care instructions must be tailored for both parents and children. Simple dressings with petroleum jelly application and/or topical antibiotic twice daily promotes healing while keeping wounds moist. Parents should be educated about signs of infection including increased redness, swelling, or purulent discharge.

Activity restrictions should be clearly communicated, particularly for surgeries where movement might compromise healing. Regular follow-up ensures proper healing and allows early intervention if complications arise.

The key to successful pediatric dermatosurgery lies in recognizing that children are not simply small adults. Their unique physiology, psychology, and healing characteristics demand specialized approaches that prioritize both medical excellence and developmental appropriateness. By mastering these pediatric-specific considerations, dermatosurgeons can achieve optimal outcomes while ensuring positive experiences that foster lifelong trust in medical care.

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SURGICAL MANAGEMENT OF HIDRADENITIS SUPPURATIVA

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Introduction

Hidradenitis Suppurativa (HS) is a chronic follicular inflammatory dermatosis affecting the apocrine gland-bearing skin. Its pathogenesis is multifactorial with immune dysregulation, genetic predisposition and environmental factors like cutaneous dysbiosis and metabolic syndrome playing a role. HS is initially heralded by the appearance of tender nodules, comedones and abscesses which progresses to discharging sinuses, fistulas and bridging scars.

Although biologics including TNF inhibitors (like Adalimumab) and IL-17 inhibitors (like Secukinumab), are the focus of research in HS management, surgical and para-surgical procedures still form a crucial part of HS management. Minor cost-effective procedures like deroofing provide immediate pain relief to patients, whereas complete surgical excision with reconstruction can guarantee cure, a feat still to be achieved by medical management.

Rationale behind surgical management in Hidradenitis Suppurativa

Advanced HS with extensive scar tissue, low-pH localized abscesses and aberrant lesional vascularity impede pharmacotherapeutic agents like antibiotics from reaching their site of action and working appropriately. Furthermore, biological therapy is primarily directed at curtailing the inflammatory response of the body rather than treating the underlying pathology. Moreover, ultrasonographic studies have demonstrated that patients with subcutaneous involvement, railway sign on ultrasonography (USG), higher number of tunnels show poor response to treatment with adalimumab. Longer duration of disease prior to initiating adalimumab is another risk factor for adalimumab non-responsiveness.

Thus, surgical management has two roles:

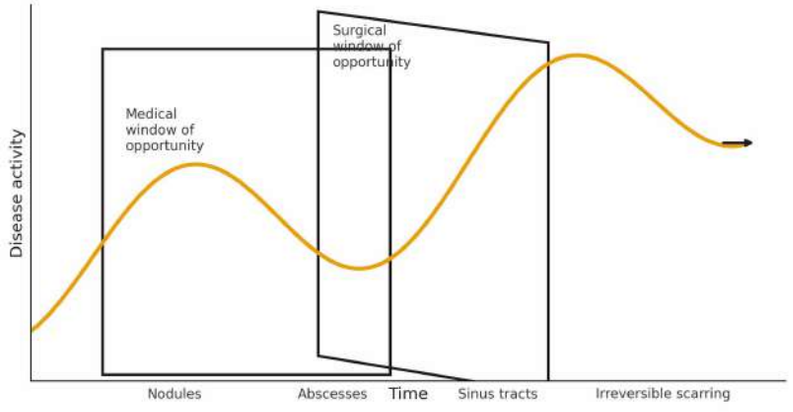
i) early drainage/deroofing to relieve pain and complement pharmacotherapy
ii) definitive cure in recalcitrant disease via complete excision

Surgical management in HS

Surgical treatment in Hidradenitis Suppurativa includes (Table 1):

Procedural treatments	Surgical treatments in early disease	Surgical treatments in late disease
Laser hair reduction	Incision and drainage	Complete surgical excision and reconstruction (Wide local excision)
Intralesional steroid injections	Standard deroofing	
Cryosurgery and intralesional cryo-infusion	Setons	
Photodynamic therapy	Skin-tissue-sparing excision with electrosurgical peeling (STEEP)	
Electrosurgery		
Ablative Lasers		
Choice of surgery is decided by extent of lesions, anatomical area affected and patient's preferences. Recurrences rates vary from 26% in partial excision to 5% in complete excision.		

Preoperative assessment



Early surgery is optimal at abscess formation, as walled-off lesions respond poorly to antibiotics. **(Figure 1)**

Complete surgical excision should be reserved for advanced and recalcitrant patients with poor QoL, persistent chronic pain, associated mental comorbidities (HS patients have 2-4 times increased rates of suicide) or impaired intimate relationships. As complete surgical excision itself requires inpatient management and prolonged post-operative care and restrictions, it should be reserved for severe and recalcitrant patients who deserve a lasting, resolute, durable, and definitive treatment, instead of multiple lifelong treatments that cycle between remissions and flare-ups.

It is prudent to understand that surgical treatment does not control active inflammation in sinuses tracts and active disease can impair wound healing. The landmark SHARPS randomized control trial definitively demonstrated that adalimumab given in conjunction with wide-excision surgery and healing by secondary intention was not associated with any impaired healing, wound infections, complications or hemorrhage.[1] Moreover, studies have demonstrated that adalimumab-plus-surgery outperforms solo adalimumab treatment.[2] Thus,

complete surgical excision should be done when the patient is in remission, without stopping active treatment.

Preoperative care for HS patients includes controlling disease activity, weight reduction, smoking cessation, treatment of superinfection and appropriate wound management. Post operative concerns and issues including financial implications, duration of inpatient admission, restriction of movement, possibility of requiring empirical post-operative systemic antibiotics, care of graft and follow up protocol must be discussed with the patient.

Preoperative high-frequency (≥18 MHz) USG imaging prior to wide-excision surgery helps to rapidly delineate exact extent of the disease and decide surgical margins. Additionally, color doppler helps in picking up ongoing inflammation, and ascertaining remission. USG has shown to increase surgical margins by nearly 3.5 cm and reduce rate of recurrence from 30% to 10%.[3] By better delineating the surgical anatomy USG can guide deroofing and intralesional steroid injection.

Surgical techniques in management of Hidradenitis Suppurativa

1. Incision and drainage (I&D):

I&D is primarily used for immediate pain relief by allowing drainage of tense fluctuant tender abscesses and preventing sepsis. Following administration of local anesthesia, an incision is used to drain the abscesses cavity. Low-pH in abscesses may blunt lignocaine action, necessitating concurrent cryo-anesthesia or preoperative sedation. Finally, I&D is an emergency procedure for pain relief and is associated with nearly a 100% recurrence rate.[4]

2. Deroofing:

Deroofing involves removing the 'roof' i.e. externalizing nodule, abscess or sinus tract by incising the most superficial surface of these lesions. The underlying sinus tract can be identified clinically by visualization and palpation, probing, injecting methylene blue or with high frequency ultrasonography (HFUS). The roof of the lesion can be divided using a traditional scalpel or with energy devices like radiofrequency ablation or ablative CO2 lasers. A mini deroofing technique with a 5mm to 8mm biopsy punch has also been described.[5] The content of the lesions is debrided and the floor is left to gradually re-epithelialize with secondary intention.

Deroofing may be combined with sinus tract excision in patients with moderate disease, and this has been associated with lower recurrence rate and similar healing times.

3. Setons:

Treatment with setons involves insertion of surgical-grade chord (E.g. Silicon loop, non-absorbable sutures) through a fistula tract, with a knot outside the tract to create a loop, with the aim of aiding healing, by facilitating continuous drainage along the seton and preventing the surface of the wound to heal.

Loose setons are tied with the objective that the encircled tissue has no tension are applied to facilitate effective drainage. While setons have traditionally been used in the management of perianal fistulae, drainage setons in HS have shown to control pain and provide symptomatic relief.[6]

4. Skin-tissue-sparing excision with electrosurgical peeling (STEEP):

The STEEP technique involves electrosurgical excision of sinus roof with a wire loop tip.[7] Successful tangential electrosurgical transections are done, sparing epithelialized sinus floors and subcutaneous fat. Inflamed tunnels are curetted completely. Finally, tissue margins are checked for sinus tracts and intralesional steroids and lignocaine are injected. The STEEP procedure is done in solitary and recurrent limited lesions.

5. Lesional excision:

Complete excision of limited lesions in early HS Hurley stage I-II (ideally for lesions less that the size of a palm) can be done as a conservative treatment and can be combined with biologics to achieve sustained remission. Lesional excision has been associated with a recurrence rate of 23% and wound dehiscence of 22%.[8]

6. Complete Surgical excision:

Wide local excision and radical excision are done with the objective of removing all lesions in the affected area in a single block in one sitting.[9] The excised tissue includes lesions, scars and a margin of surrounding healthy tissue, with depth up to the deep fascia. Utmost

care must be given in perianal disease and genital disease, with the aim of preserving the tissue anatomy, physiological function and ensuring adequate cosmesis.

The defect left after excision can be closed with primary suturing, left to heal with secondary intention or can be reconstructed with skin grafts and skin flaps.

Primary suturing is only adequate to facilitate loose closure of small lesions, allowing drainage and reducing seroma and infection risk. Primary closure is associated with a high recurrence rate (probably as it's possible only in limited excisions), wound dehiscence, scarring and contractures.[10]

Healing with secondary intention may be adequate for regional excisions up to 140 cm2 in the anogenital, truncal and axillary areas. Allowing the wound to heal with secondary intention usually requires 2 weeks to 2 months and require meticulous wound care and dressing changes. It is also associated with a risk of contractures.

Split thickness skin grafts (STSG) can be utilized after complete excision to cover large wounds. STSGs can be meshed to permit greater defect coverage (can be expanded in ratios of 1:1.5, 1:2 or 1:3) and reduce chances of post operative seroma formation.[11] STSGs are a good option to cover residual open wounds on the buttocks. They can be combined with negative pressure devices to aid healing.[12]

Skin flaps (e.g., Limberg, fasciocutaneous V-Y, thoracodorsal artery perforator, anterolateral thigh) close large defects and mitigate contractures, especially over exposed neurovascular structures; they require specialized harvesting techniques and vigilant perioperative care (chances of tissue necrosis an bleeding).

Post-operative care

As patients are at a risk of developing secondary infection due to HS itself, an intra-operative deep tissue sample should be sent for culture to decide antibiotics. Empirical Clindamycin can be given till cultures are available. Skin flaps should be checked every 3-4 hours in the first 24 hours. Restriction of arm movements may be required for 2 weeks after axillary surgery, to facilitate healing and prevent tension in skin flaps. Similarly, post-perianal surgery, patients may need pressure offloading and restriction of activities for 3 weeks.

Key Takeaways

- Early surgery combined with medical treatment forms the standard of care. Patients may benefit from the surgical window of opportunity.
- Adalimumab can be continued even when opting for surgical management
- Good pre-op planning with delimitation by imaging
- Hurley I and II: Deroofing, STEEP or partial excisions
- Hurley III: Wide local excision

Figures and Legends:

Figure 2: Image in left shows preoperative image, images on right shows images after deroofing sinus tract.

Figure 3: Lesional Excision. Image on top left shows Hurley's stage II lesions with nodules and sinus tracts. Image on top right shows tissue after nodules and tracts are excised. Image on bottom left shows primary closure with suturing. Image on bottom right shows 3 months post operative image.

Figure 4 : Wide local excision and reconstruction by a LD flap. Left image shows HS grade II in rt axilla and anterior chest. Image on right shows images postr LD flap placement. Courtesy Dr Bulli Babu Boyidii Consultant Plastic surgeon GEMS and Hospital, Ragolu, Srikakulam, Andhra Pradesh and Dr Kabir Sardana, Dir Prof and HOD, Department of Dermatology, Venereology and Leprosy, Dr Ram Manohar Lohia Hospital and ABVIMS, New Delhi

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THE SURGICAL ENERGY

Energy Based NonInvasive Dermatosurgical Procedures: HIFU, RF, and Cryolipolysis

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Energy Based Non Invasive Dermatosurgical Procedures: HIFU, RF, and Cryolipolysis

Dermatology practice has been transformed by the advent of energy-based, non-invasive procedures such as High-Intensity Focused Ultrasound (HIFU), Radiofrequency (RF), and Cryolipolysis. These treatments have gained prominence for delivering measurable results with minimal downtime. This article explores their mechanisms, clinical outcomes, safety profiles, and patient selection considerations.

1. High Intensity Focused Ultrasound (HIFU)

High-intensity focused ultrasound (HIFU) is a non-invasive medical technology that uses concentrated ultrasonic waves to heat and destroy targeted tissue. Similar to how a magnifying glass focuses sunlight to a precise point, HIFU beams converge on a specific area within the body, leaving the surrounding and overlying tissue unharmed. This precise and controlled delivery of energy makes it a valuable therapeutic tool for a wide range of medical and aesthetic applications.

Mechanism and Applications

HIFU works by delivering thermal energy at precise depths of Superficial Musculoaponeurotic System(SMAS). It causes coagulation necrosis of adipocytes and collagen remodelling while sparing the epidermis. This dual action contributes to both fat reduction, skin tightening and body contouring.1 HIFU can also cause mechanical damage through a process called cavitation, where microscopic gas bubbles in the tissue oscillate and collapse, creating localized agitation that can also destroy cells.

Efficacy

A 2025 systematic review encompassing 45 clinical trials demonstrated skin laxity improvement of 18–30% on the lower face, neck, and periorbital areas, and circumference reductions of 2.5–4.5 cm in the abdomen and thighs.1 A study on abdominal fat reduction reported a mean waist circumference decrease of 3.43 cm at 8 weeks post-treatment. Further, another revealed significant enhancements in skin elasticity on the face and body at 12 weeks, with minimal discomfort and no serious adverse effects.

Side effects:

Transient erythema, swelling, and mild discomfort were reported in under 5% of patients, highlighting a favorable safety profile.1

2. Radiofrequency (RF)

Radiofrequency (RF) energy represents a cornerstone of modern non-invasive and minimally invasive dermatological treatments. Unlike laser therapies that rely on light absorption by specific chromophores, RF devices use an electric current to generate controlled, therapeutic heat deep within the skin's dermal and subcutaneous layers. This process, called selective electro-thermolysis, works on all skin types and tones with minimal risk of damaging the epidermis or causing pigmentation issues.

Mechanism and Applications

RF delivers controlled thermal energy into the dermis, promoting neocollagenesis, elastin formation, and potential adipocyte apoptosis. This promotes skin tightening, wrinkle reduction and modest fat reduction. During sessions, tissue is heated to an optimal dermal temperature of approximately 67°C to trigger remodelling. Its variants include monopolar, bipolar, and microneedling RF, tailored to specific needs.2,3

Efficacy & Evidence

A study on monopolar RF for aged facial skin confirmed significant tightening and excellent safety outcomes.2 Its efficacy for skin tightening and soft tissue remodeling, documenting increasing usage and patient demand over the past decade.3 RF is commonly utilized for the face, abdomen, arms, and thighs, with demonstrated benefits in wrinkle reduction and body contouring.4

Side effects:

Most adverse effects are mild and transient—such as erythema, edema, and thermal discomfort.4

3. Cryolipolysis

Cryolipolysis, commonly known as "fat freezing," is a non-invasive cosmetic procedure that selectively targets and eliminates stubborn fat cells. The technique is based on the principle that fat cells are more susceptible to damage from cold temperatures than the surrounding skin and tissues. This innovative treatment offers a safe and effective alternative to surgical options like liposuction, particularly for individuals who are near their ideal weight but struggle with localized fat deposits that are resistant to diet and exercise.

Mechanism and Applications

Cryolipolysis selectively reduces subcutaneous fat through controlled cooling, triggering adipocyte apoptosis while leaving surrounding tissue unaffected. It leverages controlled cooling (typically between -11°C to +5 °C) to selectively induce adipocyte apoptosis. Histologically, macrophages remove damaged fat cells over a period of weeks to months. Single session has shown reductions upto 20% or 2-5mm, clinical improvement extends upto several months. The FDA has cleared its use for areas such as the abdomen, flanks, arms, and submental region.5

Efficacy

A 2023 review reported fat thickness reductions of 2.0 to 5.1 mm measured via ultrasound, with skinfold thinning ranging from 10.3% to 28.5% across multiple studies.5 A randomized controlled trial in adolescents found significant improvements in waist hip ratio and subcutaneous fat compared to controls.6 Overall, high patient satisfaction and modest reductions make this a viable option for focal fat reduction.

Safety

Common, self - limited side effects include local erythema, numbness, swelling, and bruising. A rare but documented complication is paradoxical adipose hyperplasia (PAH), characterized by unexpected fat enlargement -occurring in up to 0.12-1% of cases.5

Comparative Insights

Efficacy

All three modalities yield modest reductions (typically 10-28% in cryolipolysis and 10-30% reduction in HIFU). HIFU appears strongest in regional contouring (2.5–4.5 cm) and skin tightening.

Safety

All are generally safe, with mostly mild and transient side effects.

- HIFU: Mild erythema, swelling, slight discomfort.
- RF: Temporary redness or edema; discomfort minimal.
- Cryolipolysis: Mild local reactions; rare PAH in a small percentage.

Mechanisms

- HIFU: Thermal plus mechanical disruption → coagulative necrosis, collagen tightening and circumference reduction.
- RF: Heating → collagen remodeling, skin tightening and adipocyte apoptosis.
- Cryolipolysis: Cold-induced apoptosis of adipocytes over time.

Clinical Considerations

- Treatment goals: Choose HIFU when combining firming and contouring; RF for broader tightening and remodeling; Cryolipolysis for discrete fat pockets.
- Skin type: All three modalities are generally safe when properly calibrated.
- Combination therapies: Multi-modality approaches can enhance outcomes (e.g., pairing RF with cryolipolysis).
- Patient counseling: Set realistic expectations and emphasize gradual results over weeks to months.

Conclusion

HIFU, RF, and Cryolipolysis form the cornerstone of non-invasive dermatosurgical fat reduction and skin tightening strategies. Selection should be individualized:

- Choose HIFU when precise skin tightening and moderate fat reduction are desired, especially in the abdomen and face.
- Opt for RF when collagen remodeling with mild fat impact is preferred, particularly over larger or laxity-prone areas.
- Use Cryolipolysis primarily for focal fat bulges, where downtime is minimal and results are gradual.

Together, these modalities offer effective, safe, and patient-friendly alternatives to surgery—enhancing physician options in modern dermatologic body contouring.

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DERMA HUMOUR THE DIGITAL GENIE IN A BOTTLE

Dr Mansak Shishak

The Digital Genie in a Bottle

There appears to be a flood of believers all of a sudden. Not that of a cult-ish, Art of Believing type, but a deluge of Manifesters. In other words, dream, and it will be yours. Wish for something, and it must happen. Ask, and you shall receive. I almost brandished it as foo-foo, before realising placebo is real, and the mechanisms for it are aplenty. So maybe, manifesting is not merely a projection of laziness, but divine intervention that technology has so far not touched, on a scalable level.

The Three Wishes is a tool commonly used in clinical psychology settings, of particular value when children are assessed for understanding their inner thoughts, they may otherwise not be able to articulate freely. In it, the counsellor asks if, granted three wishes, by their favourite deity/person/ fairy, what the child would ask for. An open-ended question, the first three stated wishes tend to be a fair indicator of the young, evolving, and impressionable mind.

Wishes do change with time and circumstances, no?

Prior to housing menacing Alexas and Roombas, or having wrists strapped with digital stalkers, there was word-of-mouth navigation instructions, hand written notes that moved from one post-box to another, and melodies that played from cassettes. Memorising phone numbers was a necessity, a basic life skill. Telegram was still alive.

From Yellow Pages, landline diallers, and Merrium-Webster dictionary (the OG open source ChatGPT, only that the user had to construct it, like Lego bricks), there was a want for faster, better, stronger.

An “If only”.

A genie did appear, ready to serve the masses. And so, three collective wishes were made, in succession.

Wish 1. Enable phone calls at any time of the day, from anywhere, with no fixed spots to pick the receiver and dial. A mobile phone booth (PCO if you will!) on the palm of the hand.

Wish 2. A newspaper, television, and radio in a single device.

Wish 3. The internet of convenience: a marketplace of all-knowing, all-listening, all-giving knowledge, with additional benefits of rumbles, and noise.

Soon enough, the third wish became an unlimited pack. The genie turned digital, for its evolutionary survival, and could move across interfaces, serving many masters. All wishes had been granted, and bliss was on the horizon. Collective intelligence gained importance, as artificial intelligence. It had become the lenient parent, the teacher that never berated, a neighbour that was never pesky, and a colleague made in heaven.

In The Monkey’s Paw, the paw is a wish generator that grants what it is asked for. The price of the wish is never revealed.

Free feasts anyone?

Events of IADVL DSB 2025 till Annual Cuticon

THEPRACTIONERS CONCLAVE- skills beyond clinical excellence- an academic feast with latest pearls in pvt practice, also with news letter release held on 22nd June 2025 at Hotel Eros attended by around 200 delegates.

STI & Genital dermatoses- a Clinical and Diagnostic video based workshop was held on 28/9/25 attended by about 180 delegates. The workshop was a unique platform where Dermatologists & Venereologistsconvened, to update their knowledge about current scenarios of STIs & Genital Dermatoses.

Science of anti ageing conclave was held on 20th July 2025 at hotel eros with a threadbare discussion on various antiageing modalities which was attended by around 200 delegates.

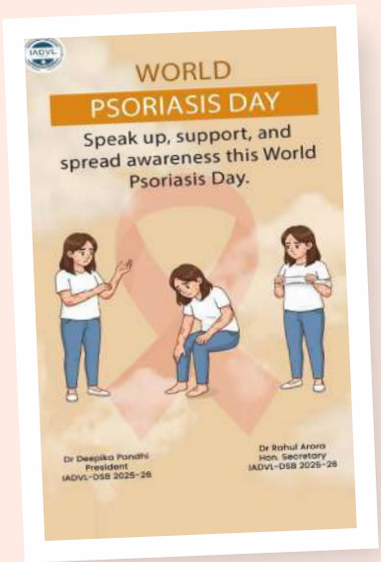
Third Monthly meet aiimsThe third Monthly Meet of IADVL DSB 2025 was held with the Department of Dermatology, All India Institute of Medical Sciences , New Delhi on 27th of September, 2025. Seventy people attended the event and we had interesting case presentations for discussion and the 3rd leg of relay quiz by Lt Col (Dr) Teghveer Singh with attractive prizes.AndAsk the Expert session- -Your Queries on Nail disorders-diagnostic and therapeutic approach answered- by Dr Chander Grover

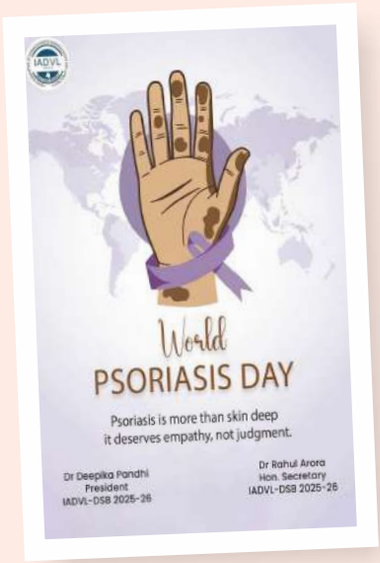
Sharing Winning videos that will also be featured on IADVL-DSB social media + will win exciting prizes!

Will be Awarded during the IADVL-DSB CUTICON on 7th December !

Psoriasis Day Video winners are:

First Prize- Dr Vishal Gaurav and team
Second Prize-Dr Munazzah Khan and Dr Urvashi Sehra





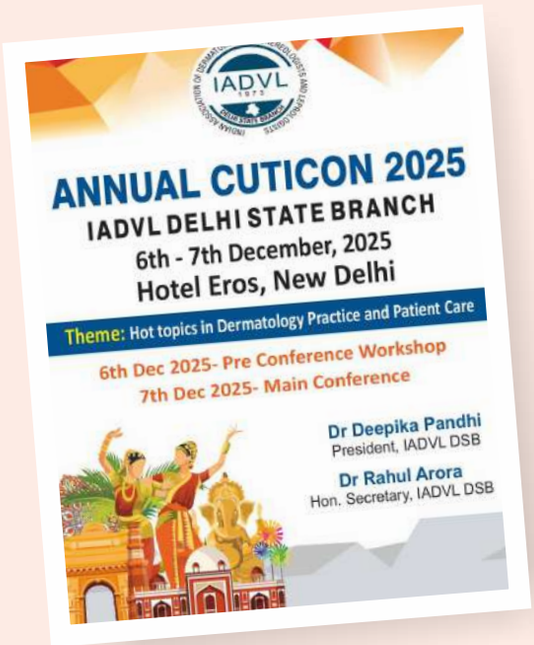
World psoriasis day- video making competition

IADVL PGPDT North Zone Workshop 2025 wasOrganized byIADVL EC & Academy, in association with SIG Dermatosurgery, IADVL Delhi State Branch, and the *Department of Dermatology & Venereology, AIIMS, New Delhi at AIIMS, New Delhi on 11th & 12th October 2025It was a live video workshop with more than 250 delegates

IADVL DSB and SIG Acne Appendageal Diseases cme on hidradenitis suppurativa was conducted on 30/11/2025 in which wonderful academic discussion was done.

Skin Health camp on 22 nd November, 2025 at
Sewa Bharti Sewa Dham Vidya Mandir Residential School, Delhi.
Amongst the 418 inmates and staff of this residential school for boys (orphans or parent unable to provide for them), approximately 300 were screened and given medicines

Upcoming Events



Annual cuticon IADVl dsb will be held on 7th december with a preconference workshop on 6th december at hotel eros

IADVL DSB Picnic will be organzised on 18th of january 2026 which will a family event full of fun activities for kids

IADVL-DSB CONCLAVE 2025 SCIENCE OF AGEING AND REJUVENATION

Dr. Vishal Gaurav Asst.
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All India Institute of Medical Sciences - New Delhi.

The IADVL-DSB Conclave 2025, held on 20th July 2025 at Hotel Eros, Nehru Place, New Delhi, was a full-day academic program focused on the Science of Ageing and Rejuvenation. Organized by IADVL-DSB, with Dr Deepika Pandhi and Dr Sachin Dhawan as Scientific Chairpersons and Dr Rahul Arora as Organizing Secretary, the conclave was an educational initiative supported by R REGALIZ.

Conceptualized and led by Dr Deepika Pandhi and Dr Rahul Arora, the meeting aimed to bridge basic anatomy, evidence-based anti-ageing interventions, and practical aspects of aesthetic dermatology. The conclave featured a balanced mix of foundational science, video demos, debates, and panel discussions, bringing together national experts and young dermatologists.

Dr Deepika Pandhi opened the meeting with an introduction outlining the importance of understanding ageing anatomy, scientific rejuvenation modalities, and ethical, safe aesthetic practice.

Scientific Highlights

- **Anatomy of Ageing:** Dr Rajat Kandhari detailed facial layers and structural ageing patterns.
- **Topicals & Lifestyle:** Dr Soni Nanda reviewed evidence-based anti-ageing agents and preventive care.
- **Debate:** Dr Jyoti Gupta (prejuvenation) vs. Dr Gaurav Nakra (need-based intervention) engaged the audience on timing of aesthetic treatments.
- **Injectables:** Video demonstrations by Dr Latika Arya (mid-face) and Dr Sachin Dhawan (lower face) focused on safe and effective filler techniques.
- **Biostimulators:** Dr Monica Bambroo (Exosomes) and Dr Swati Agarwal (PDRN) discussed regenerative options.
- **Site-specific Rejuvenation:** Dr Gulhima Arora presented a structured approach to neck rejuvenation.
- **Technology & Trends Panel:** Moderated by Dr Rohit Batra, the panel critically examined new tools, biostimulators, devices, and emerging trends.

The conclave concluded with a vote of thanks by Dr Rahul Arora, acknowledging faculty, delegates, and R REGALIZ.

Overall, the meeting provided a comprehensive, science-driven overview of ageing and rejuvenation, reinforcing IADVL-DSB's commitment to high-quality, ethical, evidence-based aesthetic dermatology education.

Continue Next Page...

PRACTITIONERS' CONCLAVE 2025

The Practitioners' Conclave 2025, held on 22nd June 2025 at Hotel Eros, New Delhi, was organized by IADVL-DSB and conceptualized by Dr. Deepika Pandhi and Dr. Rahul Arora as a first-of-its-kind meeting addressing practical issues in dermatology practice. The conclave brought together over 150 delegates and 50 faculty members, focusing on clinical practice management, procedural safety, regulatory processes, and challenges faced by private practitioners.

The event began with a lamp-lighting ceremony, followed by a welcome address by Dr. Deepika Pandhi. The IADVL-DSB Newsletter was released, and winners of the World Vitiligo Day Video Contest were announced. The winning team—Dr. Nidhi Sharma and colleagues from St. Stephen's Hospital—was felicitated with a certificate and cash prize. Senior leadership, including Dr. Rajeev Sharma and Dr. Vinay Singh, lauded the initiative.

Scientific Highlights

Laser Therapeutics: A case-based session moderated by Dr. Sachin Dhawan, focusing on technique, machine selection, and complication management.

When Procedures Go Wrong: Moderated by Dr. Anuj Pall, this panel openly discussed real-world complications in aesthetic dermatology.

Building Teams & Franchising: A business-oriented panel offering insights on HR, branding, and clinic expansion—highly valuable for young practitioners.

NABH Gunvatta Yatra Session: One of the most impactful sessions, led by Dr. Atul M. Kochhar (CEO, NABH) and Ms. Neeta Anand, highlighted:

- Minimum clinic requirements
- Documentation and workflow
- Accreditation benefits, especially for establishing quality standards and combating quackery
- A live demonstration of the NABH portal greatly simplified the understanding of the application process.

The Ayushman Bharat PM-JAY segment, featuring experts from ICMR, MoHFW, and NHA, explained empanelment, covered dermatologic conditions, and reimbursement pathways.

Pharmacotherapy & Policy Sessions: Pfizer-supported session on JAK inhibitors and small molecules explored their evidence, indications, and safe integration into practice.

Case-Based & Practical Panels: The STI Diagnosis panel, moderated by Dr. Nitin Walia, tackled complex cases and practical diagnostic dilemmas.

The final panel on Buying Devices & Clinic Challenges, led by Dr. Rohit Batra, provided invaluable guidance on equipment purchase, patient communication, and day-to-day operational issues—often described as a "masterclass" in clinic management.

The conclave concluded with a vote of thanks by Dr. Rahul Arora, acknowledging faculty, delegates, and supporters. Overall, the event successfully delivered practical learning, mentorship, regulatory awareness, and set a new benchmark for dermatology-focused CME, especially for private practitioners

STI & GENITAL DERMATOSES: A CLINICAL AND DIAGNOSTIC VIDEO-BASED WORKSHOP

Dr Bharti Aggarwal
MBBS MD Dermatology

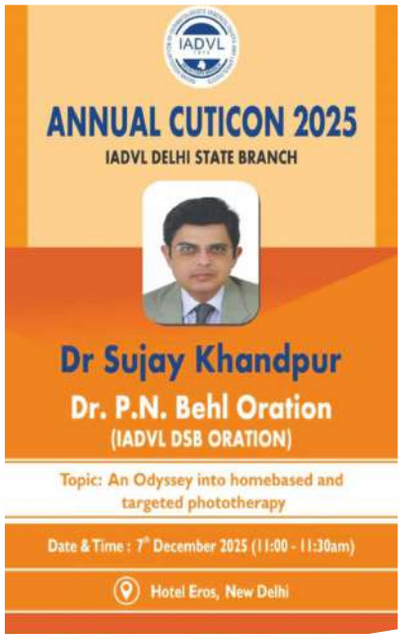
The workshop, held on 28th September 2025 brought together dermatologists, and microbiology experts on a single platform to bridge the long-standing gap between clinical practice and laboratory diagnostics in sexually transmitted infections and genital dermatoses. This was one of the first events to truly integrate video-based clinical learning with real-time microbiological demonstration, highlighting how clinic-to-lab correlation can transform STI management.

The day opened with a focused session on genital dermoscopy, using real cases and practical scenarios to illustrate its role in differentiating benign and infectious genital conditions. This was followed by an insightful discussion on general examination, history taking, and counselling, emphasising sensitive communication and targeted clinical clues that guide diagnosis even before laboratory tests are ordered. A detailed session on Genital Discharge Syndromes offered clarity on cervical and vaginal discharge patterns through a case-based, step-by-step approach. The emphasis on correlating symptoms with microscopy findings, culture results, and current research data made the topic highly comprehensive and clinically relevant. The workshop's central theme—clinic and laboratory integration—came alive during the video demonstrations on examination techniques, sample collection, smear preparation, culture methods, and result interpretation. The candidal sample-processing module was instructive, outlining direct microscopy, germ tube tests, culture modalities, and antifungal resistance interpretation, which are crucial for appropriate therapy in recurrent or non-responsive cases. The academic depth continued with a strong session on HPV, linking clinical morphology with molecular diagnostic techniques. Participants viewed detailed videos of wart evaluation, biopsy handling, and smear processing, strengthening understanding from both clinical and virological perspectives. A highly engaging case-based panel on paediatric genital dermatoses brought out subtle diagnostic nuances, illustrated through diverse and uncommon cases. The discussion on Genital Ulcer Disease, supported by structured laboratory inputs, helped decode complex presentations through syndromic and etiological approaches. This session was further enriched by expert analysis of difficult genital ulcer cases, offering practical management pathways for real-world scenarios. Current challenges in STI care were addressed through talks covering STI diagnosis in MSM, emerging patterns of antimicrobial resistance, and pragmatic approaches suited for both institutional and private-practice settings. These discussions highlighted the need for updated algorithms, sensitive history taking, and precise diagnostic strategies. The workshop also featured lively academic engagement beyond the sessions. The quiz prelims and finals drew enthusiastic participation with intense discussion, while the e-poster presentations by residents showcased fresh perspectives and research initiatives. Audience interactions throughout the day added vibrancy and curiosity, making the workshop truly dynamic.

The event successfully demonstrated how integrating dermatology with microbiology—case by case, slide by slide—strengthens diagnostic accuracy and treatment outcomes. Every session underscored the importance of connecting clinical acumen with laboratory science, reinforcing a holistic approach to STI and genital dermatology care.

The workshop concluded with deep appreciation for all faculty, participants, and residents whose contributions created a learning experience that was rich, interactive, and future-focused. This clinic-to-lab model sets a strong precedent for advanced STI education in the years ahead.

Hip Hip Hurray



STI and Genital Dermatoses-Clinical and Diagnostic Video based workshop, at New Delhi on 28.9.2025. Department of Dermatology Residents- Dr Anwesha and Dr Yasmeen got 2nd and 3rd Prize in the e Poster competition and Dr Anwesha and Dr Pratha got 3rd Prize in the Quiz.

Team West Delhi Warrior of IADVL DSB 2025-26 won the Trophy of IADVL Cricket Premier League 2025 held on 25 October 2025.

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