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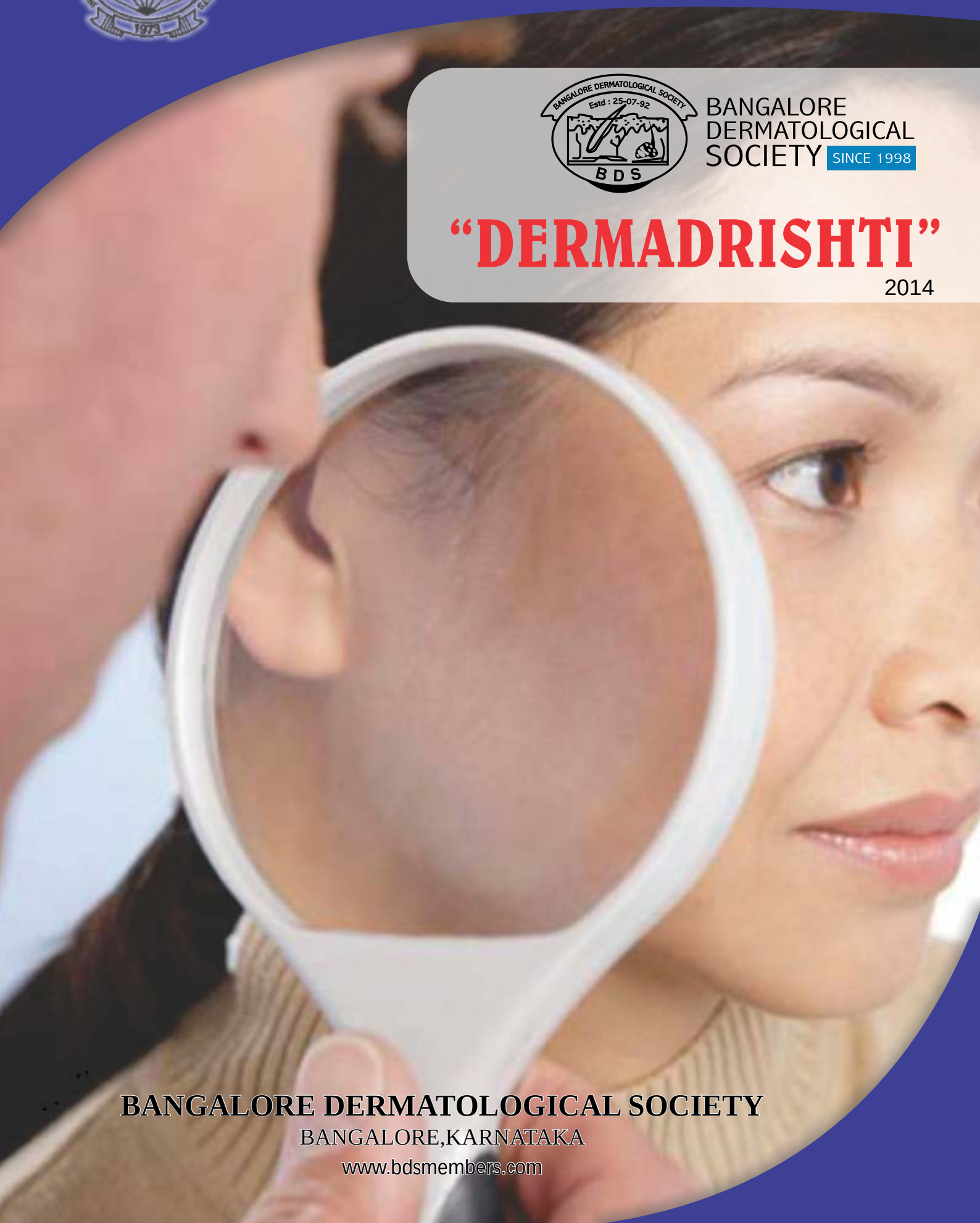

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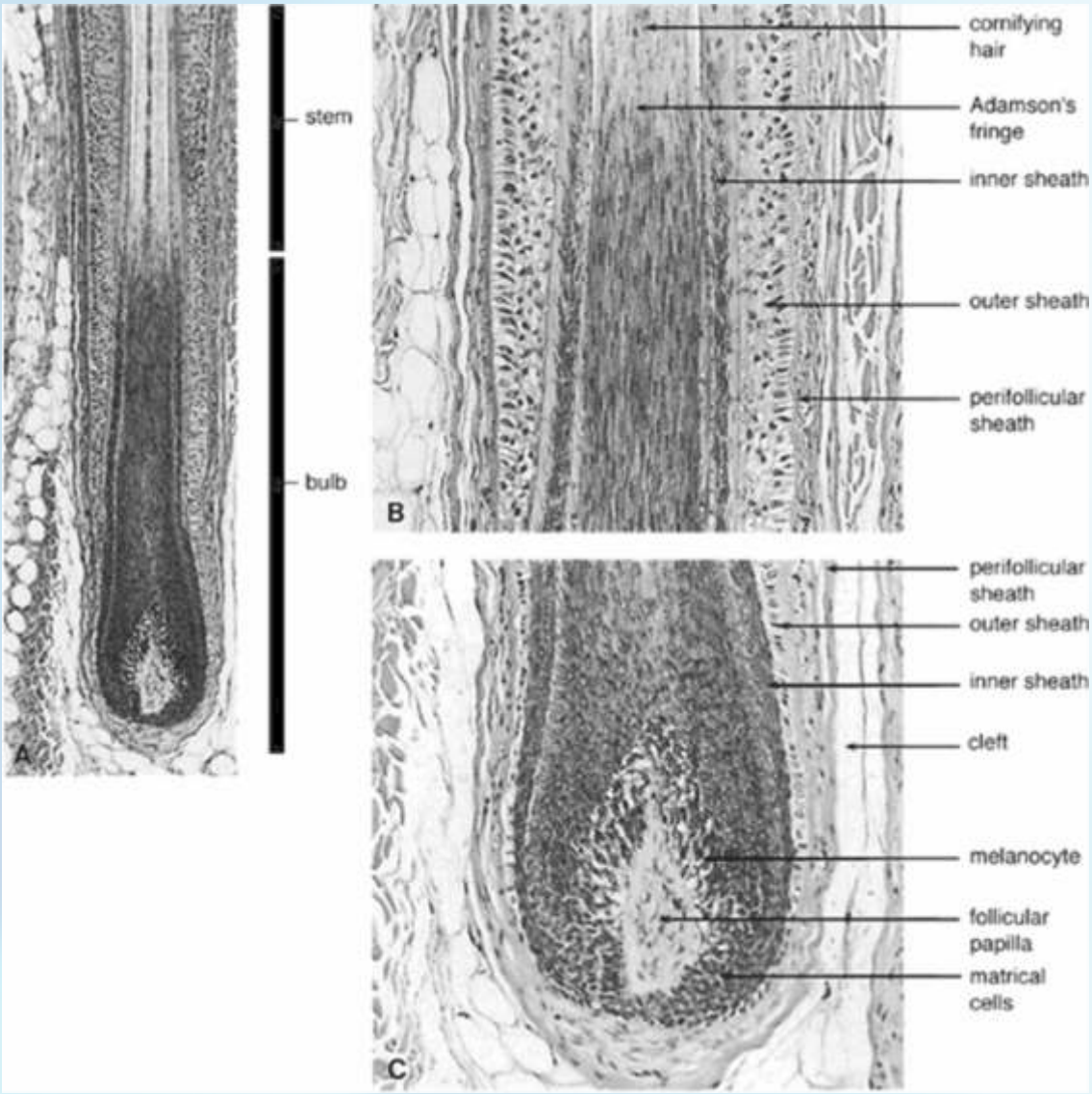
HISTOLOGY OF NORMAL HAIR FOLLICLE



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CONTENTS:

1. Proceedings of BDS CME held on 15th December 2013

The first BDS annual CME was scheduled on 15/12/2013, at City Institute. There were presentations by executive committee members on various interesting topics. Dr. Praveen, Assistant professor from M.S.Ramaiah Medical College presented an update on treatment aspects in Lichen planus. Dr. Harini presented an update on psoriasis. Dr. Sahana Consultant Paediatric Dermatologist from IGICH, presented on Emergencies an Paediatric Dermatology. Dr.Ravi Hiremagalur gave an informatics talk on pearls in Dermatology. Dr.Jayanth presented on Basics of Psychology and Micro skills. Dr. Sherly D'souza presented on sun screens.

Minutes of BDS Meet held on 19th January 2014

8th BDS CME was scheduled on 19/01/2014 at City Institute headed by Dr. Gopal, HOD department HOD Dermatology KIMS Hospital. There were interesting case presentations by postgraduates including topics on novel diagnostic signs and similes. Dr. Leelavathy. B (Associate Professor at Bowring and Lady Curzon hospital) gave an informative talk on various aspects of acne. Dr. Banu Prakash Professor at VIMS Hospital presented on Pharmaco vigilance and highlighted the importance of reporting an adverse drug reaction. Dr. Venkatram Mysore was felicitated on being elected as the President elect IADVL 2015.

Minutes of BDS meet held on 23rd February 2014

This meet was delivered under the chairman ship of (Maj Gen.) Dr. A.K.Jaiswal (Professor and HOD, Dept of Dermatology, Ambedkar Medical College) There was also an annual family get together clubbed with the meet, held at Nisarga Nursery. 150 dermatologists attended the session to make it a grand success. There were series of interesting case presentations by postgraduates. Dr. Madhan Mohan N. T. (Professor, Dept of Dermatology, Ambedkar Medical College) gave a lucid talk on oral lesions in leprosy and its varied presentations. Invited guest lecture was delivered by Dr. Hari Narayan Salunke(General Surgeon), highlighting on macrophotography in dermatology with stress on practicle tips on the use of lens attachment in mobiles and their benefits in clinical photographs.

2. BASICS OF PSYCHOLOGY AND MICRO-SKILLS OF COUNSELLING

DR. D.P. JAYANTH
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INTRODUCTION

Skin and psyche are inter- linked. Basic knowledge of psychology helps in routine dermatological practice. Psychology is defined as " the study of human behavior " . Anything observable and recordable is termed " behaviour" . It may be the sad expression on a child's face or the spoken words of a client.

Sigmund Freud's psycho-analytical theory :
Sigmund Freud, regarded as the " Father of psychology " postulated as follows :

- Man is driven by instincts of sexuality and aggression.
- Personality consists of id, ego and super-ego.
- Id-instinctive drive of sexuality and aggression. Works on pleasure principle.
- Ego-balances the demands of Id to suit reality and demands of society and works on reality principle.
- Super- ego or conscience. Works on moral principle.
- Id- ego- super ego are to be balanced for psychic equilibrium. It is an ongoing process.

Ego is intrinsically unstable and **ego defense mechanisms** are needed for mental balance. They include :

- Repression- deliberate forgetting of unpleasant experiences.
- Denial – denying reality to maintain self- image.
- Projection- blaming others for one's own faults.
- Rationalization- giving socially acceptable reason for unacceptable behaviour (excuses).
- Displacement- Pent- up feelings are expressed on a different object or person. An employee criticized by his boss, may take out his anger on his wife.
- Sublimation- redirection of energy to socially acceptable behaviour. An aggressive young man may join the army and channelize his aggression positively.

Ego defense mechanisms are needed to maintain our self- esteem and a normative ego. Over- use or persistent use of defense mechanisms results in poor coping with reality and stunts the development of the person.

Client may be using ego defense mechanisms excessively when he/she seeks help of counsellor. Counsellor has to empathize and work through that phase, for healthy resolution of the issue . Counsellor must help the client to deal with the reality of his situation and explore options for more adaptive behavior.

COUNSELLING is a helping profession and a helping process**.** A person/ client who is unable to cope with his life situation, seeks help of a professionally trained person or counsellor. Together, they explore options for the client's situation and client makes the final choice for better adaptation to his current situation. Counselling is NOT problem solving or giving advice.

SOME DON'TS IN COUNSELLING :

- Don't moralize. Counsellors are expected to be non- judgemental. Every client is a unique biological, psychological and social model.
- Don't constantly compare the client's

experience with you own. It may not be relevant.

- Don't offer advice on personal and emotional issues. Counsellor's advice may not work and makes the client dependent on the counselor. The goal of counselling is better adaptation of client to current life situation (ego-strengthening).

- Don't tell the client that they don't feel a certain way (eg., 'Of course you are not depressed') . Counsellor must validate the client's feelings and work through them.

What to do if things go wrong:

- Don't panic
- Continue to listen to the client.
- Suggest that someone else be brought into the relationship (a relative or another counselor)
- Ensure that you know where the client is going after the counselling interview.
- If you are very worried, telephone for help.
- Always keep a list of the telephone numbers of other helping agencies (psychiatrist). Counselling is only for neuroses or mild mental illnesses like anxiety, stress or depressional. NOT for psychoses or major mental illnesses wherein patient has lost touch with reality.

MICRO- SKILLS OF COUNSELLING :

Micro skills are the single communication skill units (for e.g. questions, interpretations) of the interview. They are taught one at a time to ensure mastery of basic interviewing competencies .

Micro Skill Hierarchy- 5 Stage Interview Structure :

- Initiating - rapport.
- Gathering data
- Mutual goal setting
- Working- exploring alternatives and confronting incongruity
- Terminating and generalization to daily life.

The moment client walks into the chamber, the counsellor must focus on the client. The client must be greeted warmly and made to sit comfortably. Complete privacy and focused attention on the client is mandatory.

Psychologist ***Egan's Listening behaviour*** includes :

SOLER :

- **S**itting squarely- counsellor must face client squarely.
- **O**pen position- counsellor must not cross his legs.
- **L**eaning forward- slight forward lean of counselor towards client helps in better rapport.
- **E**ye contact- counsellor must not stare at client or avoid eye contact. Breaking eye contact is advised.
- **R**elaxing- counsellor must be in a relaxed frame of mind while counseling. Body language of counsellor must also be relaxed and easy- going.

ATTENDING BEHAVIOUR OF COUNSELLOR :

Counselling is called " talking therapy". But, the most important component is
" active listening " on the part of the counsellor.

BASICS TO COMMUNICATION :

Individually and culturally appropriate -3V's +B

- **V**isuals,
- **V**ocals,
- **V**erbals, &
- **B**ody language

Verbal tracing and selective attention :

- The client has come with a topic of concern
- Stick with the client's story.
- Was the client able to tell the story?
- Stay on topic.
- Number of major topic jumps.
- Did shifts seem to indicate interviewer interest pattern ?
- Did the client have the majority of the talk time?

OPEN ENDED QUESTIONS :

- Are those that can't be answered in a few words. They encourage others to talk and provide you with maximum information.
- Could, what, how, why, what else – BASIC QUESTION STEM

CLOSED QUESTIONS :

- Can be answered in a few words as sentences. They have the advantage of focusing the interview and obtaining the information.
- Is, are, do……..

ENCOURAGING AS THE SKILL OF ACTIVE LISTENING :

Variety of verbal and non verbal means- to prompt client to continue talking

- Open hand gestures
- Phrases- un-huh
- Simple repetition of key words the client has uttered
- Re statement- repetition of two or more words exactly as used by the client
- Appropriate smile
- Interpersonal personal warmth.

PARAPHRASING :

Feed back to the client the essence of what has just been said.

- The listener shortens and clarifies the client's comments.
- Para phrasing is not parroting- but using some of counsellor's words + important words of the client.

SUMMARIZATION : Similar to paraphrase, but used over a long time span. Attention to feelings is often the part of an effective summarization. At the end, the client is asked to clarify if the counsellor's summary is accurate ("check- out questions").

Summarization can be done in the beginning, in between the session and ending of session.

OBSERVATIONAL SKILL :

One of basic listening sequences - observing one's own and the client's verbal and non-verbal behaviour as well as discrepancies and incongruities that may occur in the session.

Client may say " I am not bothered about my severe pimples". But client may have clinched fists and may be crying. Caring confrontation of the discrepancy is needed from the counsellor.

Counsellor may be disturbed or uncomfortable with some clients. Counsellor can refer to another colleague or seek outside help.

REFLECTION OF FEELINGS :

As a foundation of client experiences- involves observation of emotions, naming them, and repeating them back to the client. Counsellor recognizes key emotional words expressed by the client. Also, Counsellor should recognize unspoken feelings

expressed non verbally and check out for accuracy .

EMPATHY :
Counsellor must try to drop his/her own preconceptions and really listen to the other person in order to try to enter their 'frame of reference". We do not empathize if we constantly compare the other person's situation with our own.

Empathy involves a certain 'forgetting of self" in order to give ourselves up to the other person. Without some appreciation of the other person's world-view, we run the danger of moralizing, advising and of generally getting the wrong end of the stick.

At the same time, counsellor must maintain some emotional distance from the client and not over – identify with the client. If client cries during counseling, counselor must not cry. Ideal empathy with every client is not possible. It is to be strived for in every counselling situation.

CARING CONFRONTATION :

Counsellor supports, while challenging the client. A supportive challenge in which incongruities and discrepancies are noted and then feedback is given to the client.

It is the most powerful of the micro skills. A client with severe pimples may say " I am not bothered about my pimples ". But, she may be crying while talking. Counsellor must gently bring up the discrepancy in verbal and non-verbal behavior and deal with the disturbed emotions.

It rests solidly on effective listening and observing. It is not a direct, harsh challenge . It is not going against the client. It gives new insights to the client about their own self-defeating behaviors (non –compliance with therapy, self medication with topical steroids etc).

SUMMARY : Basic knowledge of psychology helps in interacting with clients. Micro-skills are useful tools in counselling. Healthy-doctor patient relationship is crucial for good clinical outcomes – in this day of consumerism and litigation.

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3. Emergencies in Pediatric Dermatology

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Introduction

Dermatological emergencies constitute about 4% of all pediatric emergencies care. The main educational objectives are to know the conditions causing acute skin failure in children, recognition of warning signs and clinical clues for early diagnosis and effective management.

Classification

Pediatric dermatological emergencies can be classified into primary dermatological emergencies, where skin is the only target and secondary to systemic illness. [1] There are few conditions that are not true emergencies but require ICU management.

Table 1: Classification of dermatological emergencies

Primary Dermatological emergencies

A. Erythroderma

1. Erythroderma in neonates

Infections	Staphylococcal scalded skin syndrome Neonatal candidiasis Congenital syphilis Norwegian scabies
Immunodeficiency	Omenn's syndrome Wiskott-Aldrich syndrome GVHD
Ichthyosis	Collodion baby Harlequin ichthyosis Non bullous ichthyosiform erythroderma Lamellar ichthyosis Bullous ichthyosiform erythroderma Netherton syndrome Sjogren-Larsson syndrome Neutral lipid storage disease
Metabolic disorders	Biotidinase deficiency Essential fatty acid deficiency Acrodermatitis enteropathica Cystic fibrosis
Drugs	Antibiotics-vancomycin, ceftriaxone Antiepileptics Anti tubercular drugs NSAIDS
Inflammatory dermatoses	Seborrheic dermatitis, Atopic dermatitis PRP, Psoriasis, Diffuse cutaneous mastocytosis, Leiner's disease

2. Erythroderma in children

- Ichthyosis
- Atopic dermatitis
- Infestations - Norwegian scabies
- Papulosquamous disorders - Psoriasis, PRP
- Drugs
- Metabolic/ Nutritional - Kwashiorkor, Acrodermatitis enteropathica, cystic fibrosis
- Cutaneous T cell lymphoma
- Miscellaneous – Kawasaki's disease, Dermatomyositis, Sarcoidosis, Pemphigus

A. Vesiculobullous disorders

- Epidermolysis Bullosa

B. Cutaneous infections

- Neonatal varicella
- Neonatal herpes infection
- Congenital cutaneous candidiasis
- Necrotizing fascitis

C. Acute toxic erythemas

- Steven Johnson syndrome
- Toxic epidermal necrolysis

D. Acute urticaria/Angioedema

Secondary Dermatological emergencies

A. Purpura Fulminans

B. Kawasaki disease

C. Sclerema neonatorum

D. Diffuse cutaneous mastocytosis

Primary dermatological emergencies

A. Erythroderma

In a retrospective study of pediatric patients attending a tertiary care children hospital, the incidence of erythroderma in children was 0.11%. [2] The various causes of erythroderma in children have been listed in Table 1. There is paucity of data regarding the incidence of various causes of erythroderma in children. Ichthyosis was the most common cause of erythroderma in published studies. [3,4]

Clinically, erythroderma presents as generalized erythema and scaling all over the body. A detailed history of age of onset, family history, consanguinity, sibling mortality, atopy, hair abnormalities, drug intake, systemic involvement and laboratory evaluation must be considered to approach a case of erythroderma.

Ichthyosis

Many congenital ichthyosis presents with collodion membrane, that helps in differentiating between different types of ichthyosis presenting as erythroderma. The new born skin is shiny, taut resembling a parchment covering the entire body. The membrane sheds within 1-2 weeks to develop autosomal recessive ichthyosis. 80-90% cases develop either lamellar ichthyosis or non bullous ichthyosiform erythroderma. Occasionally, they may present as syndromes. [5] Harlequin ichthyosis is a severe form where the child is born with an armour of thick yellow plate like scales covering the entire body, frog like facies, ectropion, and eclabium. It has a high mortality and these children do not survive. If they survive then they develop severe disabilities.

Bullous ichthyosiform erythroderma presents as ichthyosis with superficial blisters and erosions. Non bullous ichthyosiform erythroderma have mild erythema with fine scaling on the trunk and thick lamellar type of scales on extremities. Netherton's syndrome was the cause of 18% of congenital erythroderma in children. It is an autosomal recessive disorder with a triad of ichthyosiform dermatosis, atopy and hair shaft defects like trichorrhexis invaginata or trichorrhexis nodosa or pili torti. [6]

Infections

Staphylococcal infections presents with extensive blistering, erythema, tenderness, with characteristic flexural and periorificial area involvement. There is positive Nikolsky's sign with sparing of mucous membrane which differentiate it from toxic epidermal necrolysis. Congenital cutaneous candidiasis presents within 6 days of life with generalized erythematous macules and pustules and it is acquired through infected birth canal. The diaper area and oral mucosa is spared. [7]

Immunodeficiency syndromes

Congenital immunodeficiency syndromes are rarely symptomatic at birth. Clinically, presents as severe pruritic erythroderma, induration of skin, severe alopecia, diarrhea, failure to thrive, lymphadenopathy and hepatosplenomegaly.

Others

Atopic dermatitis causing erythroderma is rare in neonates. In metabolic disorders the initial lesions are vesiculobullous, psoriasiform and preferentially involves the perioral and perianal areas and later it generalizes.

Approach to management

Children with erythroderma are at increased risk of fluid and electrolyte imbalance, thermoregulatory disturbances, hypoalbuminemia, peripheral edema, hypernatremic dehydration, cardiac Failure, capillary leak syndrome, loss of muscle mass, high output cardiac failure and septicemia. Detailed work up with investigations like complete blood count, serum chemistry profiles, smears and cultures to rule out bacterial and fungal infections, skin biopsy and hair mounts must be considered to arrive at a diagnosis.

Management Principles

The basic management of erythroderma is supportive care with correction of hematologic, biochemical, metabolic imbalances and prevention / treatment of infections. [8] Topical application of emollients like white soft paraffin is used liberally to maintain the barrier function of skin. Specific therapy depends on the underlying cause.

B. Epidermolysis Bullosa

Severe form of EB simplex (Dowling-Meara), Herlitz-type Junctional EB and recessive dystrophic EB can be lethal in neonatal period. Death can occur due to sepsis. These children must be managed in ICU specialized in EB care.

C. Neonatal infections

Neonatal varicella is usually transmitted from maternal varicella occurring within 5 days before or 2 days after delivery. Neonatal herpes presents at or soon after birth. There are 3 types of infection localized, mucocutaneous, disseminated and CNS infection. Vesicles appear at 2nd and 12th day of life. Complications include hepatitis, pneumonia and DIC.

D. Drug Reactions (SJS/TEN)

Typically occurs 4-28 days after new drug. Anticonvulsants (carbamazepine, phenobarbitone, phenytoin) are the most common etiology for drug reaction in children. There is no significant risk after 8 weeks. At least 2 mucosal surfaces are involved in SJS. Toxic epidermal necrolysis presents as fever, dusky erythematous rash, blistering, and separation of large sheets of epidermis with systemic involvement. If not managed early may lead to septicaemia and death. [9]

The main stay of treatment is discontinuation of the offending drug and intensive supportive care. IV immunoglobulin is the primary drug of choice in children. It is very safe and well tolerated. Side effects are less than 5% and resolves within few days. [10] Average dose is 2g/kg (1.2-4g/kg) given over 4 days.

Secondary dermatological emergencies

Purpura Fulminans

Purpura fulminans is an acute condition characterized by progressive hemorrhagic necrosis of skin. It is due to protein C or S deficiency in neonates. Post neonatally it is acquired through infections (rickettsial, streptococcal, post varicella). Clinically, presents within first 12hrs of life as symmetrical purpuric lesions on the extremities. It may lead to digital gangrene and septicemia. [11] Antibiotics, fresh frozen plasma, protein C concentrate and oral anticoagulants are the treatment of choice.

Kawasaki Disease

It is an acute febrile illness, self-limiting multisystem vasculitis of unknown etiology seen predominantly in younger children less than 4 years of age. It is

characterized by high grade fever, lip fissuring, conjunctivitis, cervical lymphadenopathy and truncal polymorphic non-vesicular rash. IV immunoglobulin is the drug of choice along with high dose aspirin. [11] Infliximab has been tried but its efficacy and safety in children is not well established. Prompt detections of early signs of life threatening conditions with a well equipped ICU, staff of paediatrician, dermatologist and nursing would prevent mortality in children. Counselling to parents is essential.

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4. Case report with Quiz

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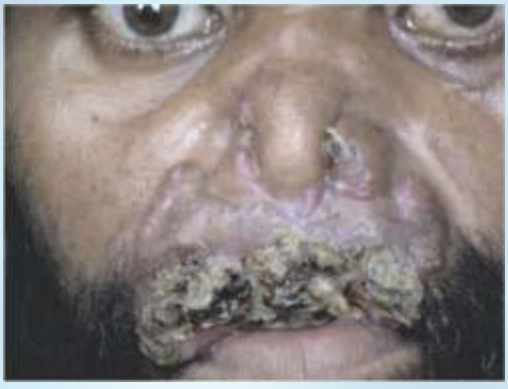
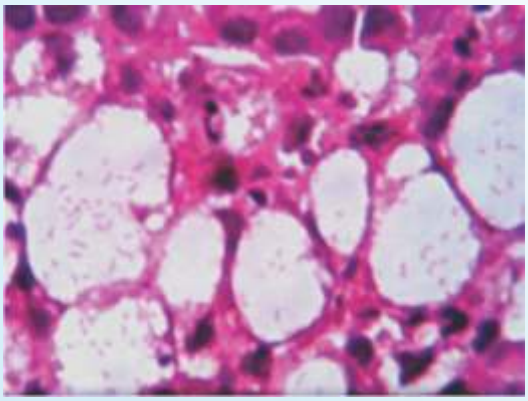
DEPARTMENT OF DERMATOLOGY
M S RAMAIAH MEDICAL COLLEGE AND TEACHING HOSPITALS

A 20 year old male presented with history of swelling of the upper lips, since 8 years. There was history of repeated episodes of bleeding from the lesions with destruction of nose, since 2 years. The lesions initially started as pimple-like and gradually spread to involve the nose and upper lip. There was history of loss of teeth and also patient had history of fever, on and off. There was no history of loss of weight or appetite, and there were no genital lesions. Patient's younger brother was suffering from similar complaints.

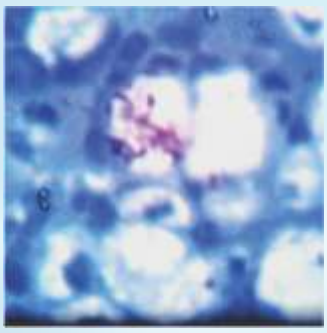
On examination, there were erythematous to skin coloured infiltrated plaques, with surrounding satellite nodules, involving the upper lip and nose. There was ulceration with crusting seen over the plaque. There was destruction of the alar cartilage with flattering of nasal bridge and stenosis of the anterior nares(figure 1).



Oral mucosa showed ulceration over hard palate, soft palate and uvula. Routine investigations were within normal limits. X-ray skull showed haziness of both maxillary sinus with no bony changes. CT- PNS revealed stenosis of nares and maxillary sinus was obscured by thick fibrous tissue. Biopsy showed extensive ulceration and severely dysplastic stratified squamous epithelium with dense mixed inflammatory cells infiltrate composed predominantly of lymphocytes, plasma cells, many foamy macrophages containing eosinophilic material and a few neutrophils(figure 2).



Giemsa stain showed foamy macrophages containing granular material(figure 3) .

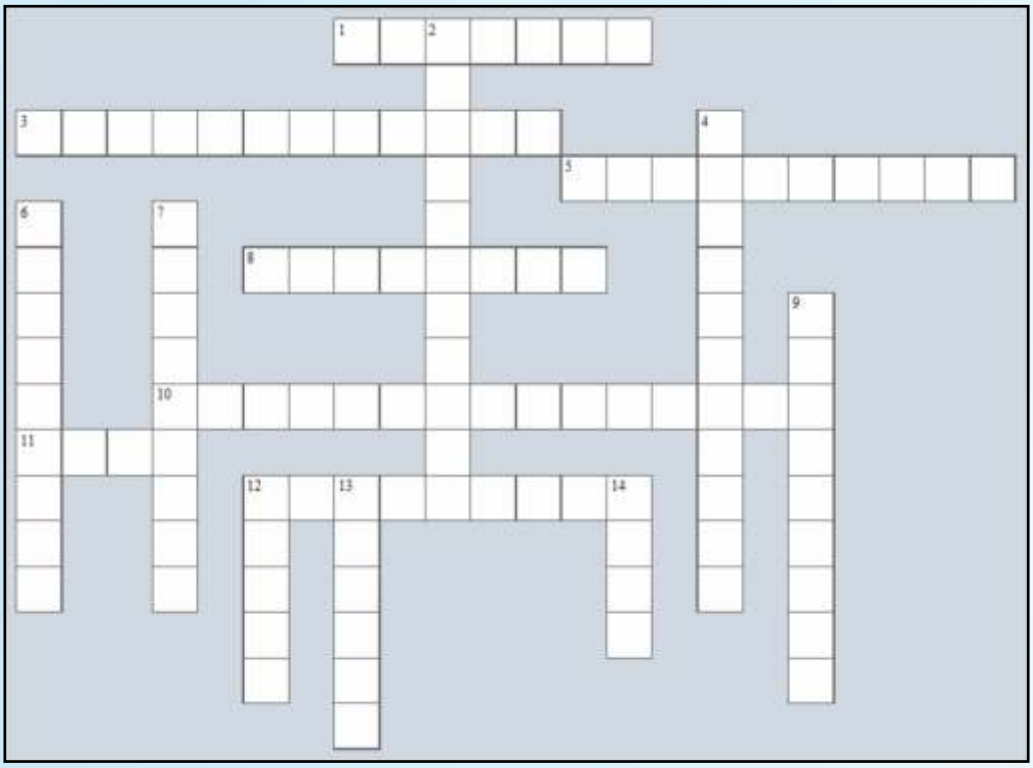


Patient was treated with oral tetracycline 500mg qid for 2 weeks with resolution of lesions.

WHAT IS YOUR DIAGNOSIS?

(Answers to Quitz on Page No.15)

5. Crossword on Drugs By Dr. K.N. Shivaswamy



Across

1. The only medical treatment for Rhinosporidiosis (7)
3. Antiplatelet drug for Trichomoniosis (12)
5. This analgesic can be used as treatment for Actinic keratosis (10)
8. The first topical antimycotic discovered by NewYork State Health Laboratories (8)
10. This drug can also be used to reduce bladder toxicity due to cyclophosphamide (15)
11. This drug has garlic smell (4)
12. Macrolide immunosuppressive acts via signal transduction (9)

Down

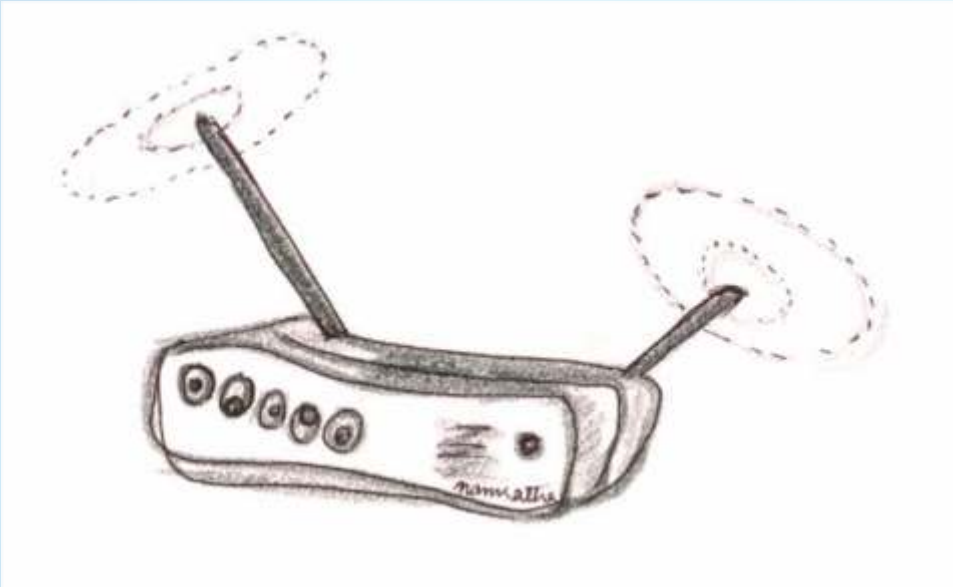
2. This drug can beat infantile haemangioma to shrink (11)
4. This drug can cause eosinophilic enteropathy (11)
6. Antihypertensive given for hyperhidrosis (9)
7. Drug for HIV can cause renal calculi (9)
9. This biological inhibits the interaction of CD2 and LFA3 (9)
12. This can be used for alopecia areata who feel sad about their problem (5)
13. This combination photochemotherapy reducces the incidence of cutaneous malignancy (6)
14. Drug of choice for subcutaneous phycomycosis, can cause lacrymation and cramps when used in excess (4)

(Answers to Crossword on Page No.16)

6. DERMACARTOONS BY DR. NAMRATHA

IDENTIFY THE SIGNS INDICATED BY THE DERMACARTOONS

1)



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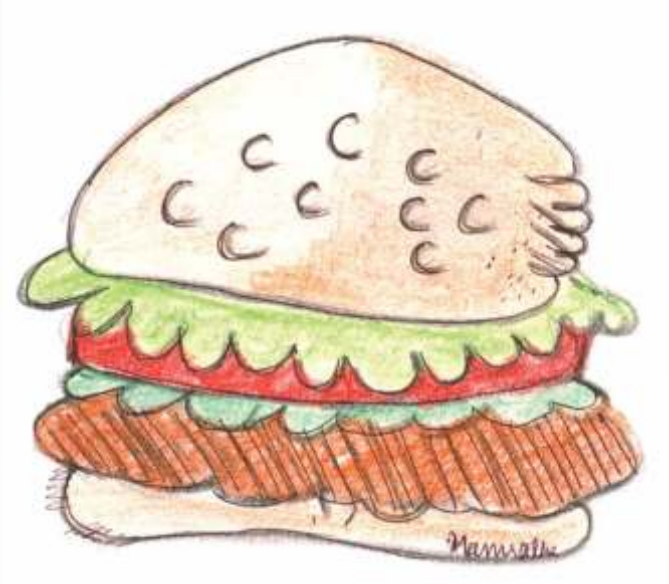


(Answers to Dermacartoons on Page No.17)

7. Answers to Case report & quiz

DISCUSSION:

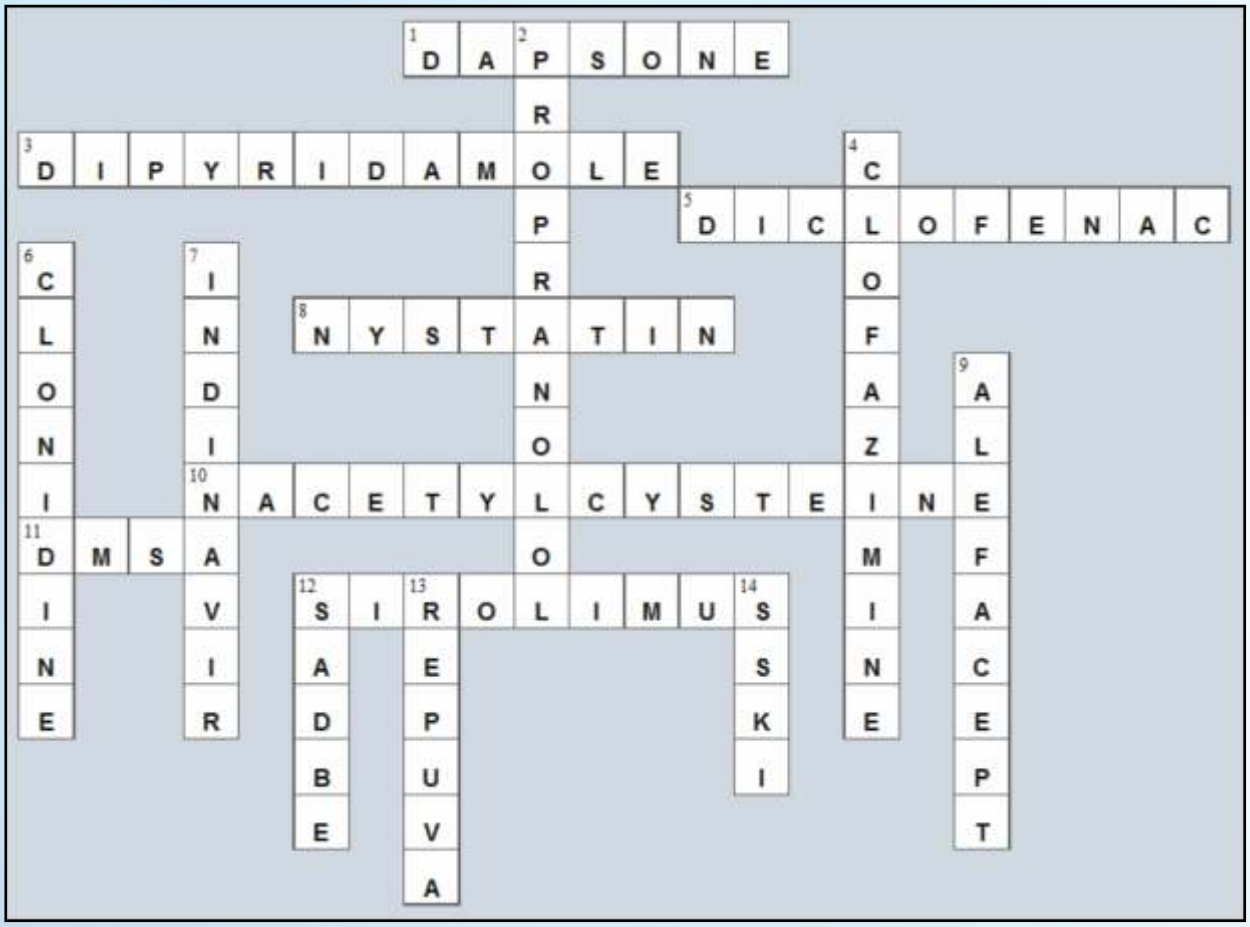
Rhinoscleroma is a chronic slowly progressive, potentially fatal infection and mildly contagious disease. It affects upper and the lower respiratory tract. Klebsiella rhinoscleromatis is the causative organism. It is a gram negative encapsulated, non-motile bacteria, 3 mm in length. Mucopolysaccharide in the capsule is implicated responsible for the damage which begins at the junction between stratified squamous epithelium of the vestibule and respiratory epithelium of the nose.

The disease onset is insidious, with various stages of evolution. There is initially a catarrhal stage followed by a granulomatous stage with noduloulcerative lesions and then there is stage of destruction and finally a sclerotic stage. Mikulicz cells and Russell bodies with plasma cell infiltration are characteristically seen in granulomatous stage. A Mikulicz cell is a vacuolated histiocyte with a poorly defined cytoplasm, which has an eccentric nucleus . There are intracellular organisms which are better visualized by Gram's, Giemsa or PAS. A Russell body is an eosinophilic, ellipsoidal structure in the cytoplasm of plasma cells. Treatment with long term antibiotic therapy is implicated. Third-generation cephalosporins, clindamycin and cephalosporin are tried. Surgical intervention is tried in sclerotic stage.

REFERENCES:

1. Inamadar A C, Palit A, Kulkarni NH, Guggarigoudar SP et al. Nodulo-ulcerative lesions over the nose. IJDVL. 2004; (70): 197-198.
2. Lucas S. Bacterial disease. In: Elder D, Elenitsas R, Jaworsky C, Johnson B Jr, editors. Lever's Histopathology of skin. 8th Ed. Philadelphia: Lippincot-Raven. p. 457-502.
3. Behera B, Devi B, Patra N. Mutilating lupus vulgaris of face: An uncommon presentation. IJDVL. 2010;76(2): 199-200.

8. Answers to Crossword



9. Answers to Dermacortoons

1. Antenna sign:

It is seen in keratoses pilaris, in which individual follicles show a long strand of keratin, when examined in tangentially incident light.

2.Hambuger sign:

Seen in trichotillomania ,

There are vertically split hairs shafts and proteinaceous material, wherein the erythrocytes which are present in the split resembling, a hamburger in a bun

10. NEWS & EVENTS

International:

ASIAN ACADEMY OF DERMATOLOGY AND VENEREOLOGY

9th – 12th April

21st Regional conference of dermatology (Asian-Australasian) incorporating the 6th Annual meeting of the Asian Academy of Dermatology and Venereology Danang, Vietnam, for more info.

visit: www.asianderm.org

ANNUAL MEETING Of SOCIETY FOR INVESTIGATIVE DERMATOLOGY (SID)

7th – 10th May

73rd Annual meeting of Society for Investigative Dermatology (SID), Albuquerque, Mexico, more info

visit: www.sidnet.org

STD PREVENTION CONFERENCE

9th – 12th June

STD Prevention Conference Atlanta, Georgia, USA, for more info,

visit: www.cdc.gov/stdconference

PEADIATRIC DERMATOLOGY (ESPD) CONGRESS

12th – 14th June

12th European Society for Peadiatric Dermatology (ESPD) Congress, Kiel, Germany, for more info,

visit: www.espd2014.com

2ND INTERNATIONAL CONFERENCE ON HIV/AIDS, STDS & STIS

25th – 26th June

2nd International Conference on HIV/AIDS, STDs & STIs, Valencia, Spain, for more info,

visit: www.omicsgroup.com/hiv-aids-std-conference-2014

10TH WORLD CONGRESS OF THE INTERNATIONAL ACADEMY OF COSMETIC DERMATOLOGY

18th – 20th July

10th World Congress of the International Academy of Cosmetic Dermatology, Rio De Janeiro, Brazil, for more info.

visit: www.iacdrio2014.com.br

22ND INTERNATIONAL PIGMENT CELL CONFERENCE

4th – 7th September

22nd International Pigment Cell Conference, Singapore, for more info.

visit: www.ipcc2014.org

5TH WORLD CONGRESS OF TELE DERMATOLOGY

18th – 20th September

5th World Congress of Tele Dermatology, Barcelona, Spain, for more info.

visit: www.sbc-congresos.com

23RD EUROPEAN ACADEMY OF DERMATOLOGY & VENEREOLOGY (EADV) CONGRESS

8th – 12th October

23rd European Academy of Dermatology & Venereology (EADV) Congress, Amsterdam, Netherlands, for more info.

visit: www.eadvamsterdam2014.org

NATIONAL:

National conference of IADVL - Dermacon 2015

Managlore

February 12th to 15th 2015

Mid cuticon 2014

Aurangabad

August 15th - 17th 2014

SARAD MEET

Mysore, Karnataka

September 4th to 6th 2015

IADVL MIDDERMACON, Hotel Rama international, Aurangabad, for more info.

visit: www.iadvlmiddermacon2014.com

Annual Conference of Indian Society for Pediatric Dermatology – ISPD, Kolkata

(14th, 15th and 16th November, 2014)

COSDERMINDIA 2014

10th – 13th July

COSDERMINDIA 2014, Mumbai, India, for more info:

visit: www.cosdermindia2014.com

ACSICON 2014

24th – 26th April

ACSICON 2014 – Annual Conference of Association of Cutaneous Surgeona of India, Vythiri, Wayanad Hills, Kerala, for more info.

visit: www.acsicon.com

State Branch events:

DERMAZONE SOUTH 2014

Puducherry

September 19th to 21st 2014.

CUTICON TAMILNADU BRANCH 2014

8th and 9th August 2014

Akash Family Club,Madurai

Contact: Organising Secretary,CUTICON TN 2014, Cuticontn2014@gmail.com

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