OPEN HOUSE

Clinical Dermatology Conclave Foundation

MARCH 28th & 29th 2026

@ Novotel & HICC Complex Novotel Hyderabad Convention Centre

Session 1 : Insights - 1

PRESENTER

Dr. Anchala Parthasarathy

Session 1 Faculty -
OH Hyderabad 2026

| Saksenaea vasiformis

- Rare emerging opportunistic fungus (Mucorales, Zygomycetes).
- Flask-shaped/vase-shaped sporangia.
- **Treatment options:**
  - IV Amphotericin B.
  - Itraconazole 200 mg BD; if no response, increase to 400 mg BD.
  - Voriconazole 200 mg BD.
- **In suspected mucormycosis:** Investigate systemic involvement (CXR, USG, PET scan).

| Asymptomatic hypopigmented elevated papules in child

- Consider histiocytosis.
- **Investigations:** CXR, skull X-ray, USG, PET (FDG uptake in thymus = poor prognosis), BRAF mutation, audiometry (direct infiltration of mastoid/middle ear).
- LCH: Single-system or multisystem.
  - **Multisystem:** High-risk (spleen, liver, bone marrow, thymus) or low-risk (skin, bone, lymph node, pituitary).
- Vemurafenib (BRAF inhibitor) can be given.

| Histoplasmosis

- **Histopathology:** Intracellular ovoid bodies with halo, budding yeast.
- **Treatment:** Itraconazole 400 mg BD.

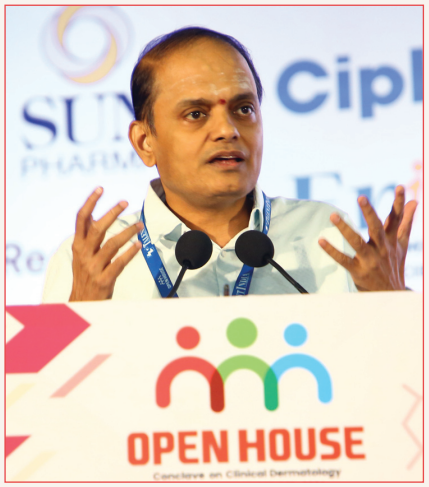
| Plaque with discharging sinus over abdomen

- **Differentials:** Mucormycosis, pyoderma gangrenosum, necrotizing fasciitis, atypical MTB, nocardiosis, actinomycosis, Crohn's disease.
- **M. abscessus:** IV amikacin + clarithromycin; clindamycin.

Session 2: Neonatal & Infantile Dermatoses

PRESENTER

Dr. Ramkumar



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| Staphylococcal Scalded Skin Syndrome (SSSS)

- **Neonatal case:** Distressed child; blood cultures negative.
- **Management:** Minimize handling; avoid topicals first 2 days; IV antibiotics first 2 days.
- **Treat as MSSA/MRSA (drugs work slowly for MSSA):** Augmentin or clindamycin.
- **Features:** Early umbilical cord stump drop; H/O preterm labor/PROM; blisters in flexural regions.
- Lincomycin syrup (10 mg/kg q12h) can be tried.

| Preterm child with pigmented macules

- Rule out chikungunya.
- **Newborn:** If not alert, think chikungunya encephalopathy (no fever).
- **Infant:** Bullae over legs + high fever; flaccid bullae with peeling (intergluteal area, erosive diaper dermatitis).
- Pigmentation spares nose; sites: upper lip, chin, malar area; no arthritis; vesicles from spongiosis.
- **Refer:** Dr. Arun Inamdar's article on chikungunya.

| Preterm skin development

- Stratum corneum forms by week 22.
- Sebum by 28th week → vernix caseosa (absent if born <28 weeks).

| Non-healing ulcer in preterm neonate (VLBW)

- Rule out Aspergillus/Mucor.
- **Preterm invasive infections:** Aspergillosis (erect, Non-septate hyphae).
- Send cultures for Candida.

| Neonatal purpura fulminans

- Rule out congenital Protein S/C deficiency (check consanguinity).
- **Rule out infections:** S. aureus, Group B Streptococcus, Acinetobacter baumannii, meningococcemia.
- PT/APTT prolonged.

| Ecthyma gangrenosum

- Not always Pseudomonas (also S. aureus, Klebsiella, Serratia).
- **Risk factors:** Necrotizing enterocolitis, recent bowel surgery, neutropenia, prolonged illness, prematurity.
- Associated with poor prognosis.

| Drug rashes & infections

- **Morbilliform drug rash:** Maculopapular + confluent.
- **Rubeoliform:** Non-merging rash.
- **Measles:** Palms involved; child not irritable; barking cough; purulent conjunctivitis.
- **Kawasaki:** Highly irritable; intergluteal clefting; psoriasiform lesions after 3 weeks.
- **Scrub typhus:** High fever, rubeoliform rash (merges but clear margins).
- **Mycoplasma:** Mostly >1 year.

| MISC in children: When to suspect

- Acute urticarial rash (sudden onset).
- Orbital erythema/edema.
- Scrotal edema.
- Systemic collapse (hypotension requiring inotropes/ventilation).

| Other pearls

- **Omenn syndrome (AR SCID):** Erythroderma, hepatosplenomegaly, recurrent infections.
- IgE: Last to form.
- **Port-wine stain:** Early imaging
- **Large CMN:** Whole brain/spine MRI within 3 months (benign proliferative nodules possible).
- **Histoplasmosis:** Halo around organism.
- **Leishmaniasis:** Marquee mirror appearance (intracellular organisms align along vacuole rim in histiocyte); CD1a+ (mimics LCH).

Session 3: Choosing Systemic Drugs

PRESENTER

Dr. Kabir Sardana

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| Mycetoma investigations

- Smear, MRI, PCR, culture, antifungal sensitivity, sequencing.
- **Dot-and-circle sign:** Nocardiosis.

| Nocardiosis treatment

- Avoid injectables/grave side effects.
- Linezolid + meropenem.
- **Carbapenems:** Effective vs. Gram+ve, Gram-ve, Nocardia.
- Doxycycline instead of Septran DS.
- **Regimen (Kabir Sardana article):** Linezolid 600 mg BD× 3 months + TMP/SMX (1200/240 mg) ×6 months.
- **If fails:** Faropenem 200 mg TDS ×3 months + TMP/SMX × 6 months.
- **Welsh regimen:** Outdated (IV, compliance/audiological issues).

| PLHA + genital ulcer (Donovanosis case)

- **Biopsy:** Giemsa stain.
- **Drugs:**
- Doxy 100 mg BD ×3 weeks.
- Azithromycin 500 mg OD ×3 weeks.
- Ciprofloxacin 750 mg BD ×6 weeks.
- Gentamicin 75 mg IV BD ×3 weeks.
- **Intracellular organisms:** Host immunity key (better response with higher CD4 in PLHA).
- **Unresponsive genital warts:** Rule out HIV/low CD4.

| Erythema annulare centrifugum (EAC)

- **Investigations:** Skin scrapings, biopsy, ANA, Mantoux, USG, CXR, CT, CRP.
- **Treatment:** Azithromycin, low-dose minocycline 50 mg, macrolides, metronidazole, cyclosporine.
- **Annular recurring EAC:** Minocycline.

| Thalidomide-responsive dermatoses

- ENL, resistant lichen planus, prurigo nodularis, CAD, actinic prurigo, AHLE, aphthosis.

| Colchicine off-label uses

- Neutrophilic dermatoses, recurrent aphthosis, LCV, palmoplantar pustulosis, macular amyloidosis.

| Pyoderma gangrenosum (PG)

- **Bullous PG:** Reduce pain/inflammation; manage underlying condition; cyclosporine initially + minocycline maintenance (antibiotic + parabiotic effects).
- **Vegetative PG:** Infection control; thalidomide (100 mg OD → 150 mg).

| Generalized pustular psoriasis (GPP) in children

- **General:** Antibiotics + fluid/electrolyte balance.
- **Conventional:** Phototherapy, MTX, acitretin (>8 years per package insert), cyclosporine, colchicine.
- **Colchicine:** Efficacious in GPP/palmoplantar pustulosis/neutrophilic dermatoses; children: 0.5 mg OD-BD; maintenance 0.5 mg OD to prevent relapse.

| Netherton syndrome vs. EAC

- Netherton: F/H+, recurrent/relapsing; hair findings not universal.

Session 4: Classic Teaching

PRESENTER CASE 1

Dr. Soumya Jagadeesan

Session 4 Faculty -
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| Case 1: Perplexing papules

- Failure to thrive, recurrent URTI, persistent umbilical D/S, recurrent otitis media → Think immunodeficiency.
- Hypopigmented macules + molluscoid lesions + organomegaly → LCH (purpuric lesions, diaper dermatitis-like).
- LCH survivor → Later CML possible; TET mutation = bad prognosis.
- **LCH Ix:** CXR, CT lung/liver, PS, BM.
- **Wegener's:** Otitis media presentation.
- **Molluscoid-like lesions:** LCH, histoplasmosis, penicilliosis, coccidioidomycosis, cryptococcosis, histoid Hansen.

| Case 2: Dr. Laxmisha - 34 y/o male farmer, painful R hand swelling ×3 months

- **O/E:** Discrete erythematous tender nodules in linear configuration (dorsum little finger/hand/forearm); purulent discharge.
- **DDx:** Bacterial SSTI, nocardiosis, atypical mycobacteria, nerve abscess, phaeohyphomycosis, sporotrichosis, leishmaniasis, melioidosis (rare).
- **FNAC/biopsy:** Necrotizing granulomatous inflammation.
- **Culture:** NTM (M. marinum/ulcerans) after 36 days; line probe assay for ID.
- **Empirical:** Itraconazole + rifampicin + doxy + clarithromycin.
- **Treatment:** Clarithromycin + ethambutol ×4 months (continue 1-2 months post-resolution).

| House special entrees:

- Repeat cultures (better yield).
- Biopsy ulcer sides.
- **Culture:** No saline needed (just tissue).
- **M. marinum:** PCR > culture (₹6-7k); grow at 30-34°C.
- **M. abscessus/chelonae:** Rapid growers.
- IFN-γ assay futile (30% false-positive + in renal patients).
  Differentials (linear nodules/plaques in farmer): Nocardiosis, ATM, phaeohyphomycosis, sporotrichosis, leishmaniasis, melioidosis (local endemicity/profession/immunostatus).
- PAN bacterial/fungal DNA PCR (Coimbatore lab).
- **Biopsy:** 1 in formalin (HP), 1 in saline (culture); AFB in sterile saline (2 temps).

| Case 3: Extranodal NK/T-cell lymphoma

- Chronic non-healing genital ulcer → Rule out HSV, PIN/SCC, penile lymphoma.
- **Presentation:** Single painless ulcer preputial mucosa; H/O HRSB; erythematous indurated ulcer (dorsal flap+); firm LAP.
- **Bx:** Deep dermal lymphoplasmacytic infiltrate; atypical small-medium lymphoid cells (irregular folded nuclei, prominent nucleoli, angiocentricity).
- **PET-CT:** Nasopharyngeal + penile uptake; EBV PCR+.

| House special entrees:

- Rare GU tract involvement = grave prognosis.
- **C/C non-healing genital ulcers:** HSV, PIN/SCC, penile lymphomas; persistent HSV (non-tender); donovanosis (vascular, bleeds); chancroid (smell); TB/amoebic ulcers.
- Tissue PCR; check oral/perianal.
- Angiocentric DDX: B-cell lymphoma, EBV lymphomatoid granulosis, NK/T-cell.
- Track EBV titres.

| Case 4: Paradoxical reaction to ATT in lupus vulgaris

- Superficial biopsy: Psoriasis-like HPE.

Session 5: Genodermatoses Workup

PRESENTER

Dr. Sahana

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| Resources & uses of genetic testing

- OMIM website.
- Confirmation, genetic counseling, therapy.
  Harlequin ichthyosis vs. Collodion baby

Feature	Harlequin Ichthyosis	Collodion Baby
Skin	Armor-like with deep fissures	Parchment-like
Prognosis	Poor	80% → ARCI; 20% self-limiting; favorable usually
Collodion membrane	-	Rule out lamellar ichthyosis, Netherton, trichothiodystrophy, Gaucher type 2

- **Erythroderma at birth:** Ichthyosis, Netherton, immunodeficiency, metabolic.

| Approach to suspected genetic condition

- History (consanguinity).
- 3-generation pedigree.
- Cutaneous/systemic exam.
- OMIM/Google.
- Labs: H/P, IF, hair microscopy, dermoscopy, Wood's lamp.
- **Genetic testing:**

- Cytogenetics (karyotyping).
- **Molecular:** WES (₹7k), Sanger.
- Metabolic.
- **Sample:** 3-5 ml blood (generalized); skin biopsy (mosaic/post-zygotic → DNA from cultured melanocytes/keratinocytes).
- Trio analysis (parents).

Session 6: Immunosuppressives in Pediatrics - Panel

MODERATOR

Dr. Raghavendra Rao

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| Methotrexate (MTX) in pediatrics

- **Dose:** 0.2-0.6 mg/kg; min age 2 years.
- **Oral solution:** 2 mg/ml (Adxate-OS).
- **Folic acid:** Avoid same day as MTX; no outcome difference (daily/weekly ×3/5 mg).
- **LFTs:** Continue if AST/ALT <2x (workup NASH); <3x low-dose.
- **Infection:** Stop 1-2 weeks (TLC <3k, Plt <1L, PMN <1k).
- **Indications:** Psoriasis, morphea (high-dose 0.6 mg/kg ×1 year), AD (maintenance, chronic lichenoid), dermatomyositis, lichen sclerosus, LP.
- Not FDA-approved pediatric psoriasis (Chinese articles available).

| LP in children (alternatives)

- Acitretin, dapsone (post-HLA B*13), cyclosporine.

| Acitretin

- Avoid peak growth; females SMR 2-3 (breast bud, age 9-11); males SMR 3-4 (genital hair).

| Cyclosporine (CyA) in peds

- No age bar; dose on ideal body weight (caution obese).
- Hit hard, then taper.
- ≥6 months continuous → consider discontinuation.
- **After 3 months:** Weekend CyA (5 mg/kg).
- **Monitor:** Age-appropriate BP (correct cuff/height/weight); hyperkalemia, hypomagnesemia (cramps); S. creatinine (early morning); reversible papilledema/hypertrichosis; hypertriglyceridemia (obese + acitretin).

- **Taper:** Maintain dose 1 month post-improvement, then taper.

| Morphea

- Prednisolone + MTX.

| OMP in children

- Avoid (betamethasone/dexa: 6-8x anti-inflammatory but 18x bone-suppressive).
- Prefer prednisolone daily + MTX.

| Tofacitinib (Tofa) in children

- Off-label >2 years; AA/vitiligo.
- **<40 kg:** 5 mg OD; >40 kg: 5 mg BD.
- **S/E:** Dyslipidemia, transaminitis, retinal vein occlusion.
- **TB risk:** MTX/Secukinumab (1.5x), adalimumab (2.5x), Tofa (8x).

Session 7 : Genodermatoses Workup

PRESENTER

Dr. Balasaraswathi

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| Evaluate chronic/recurrent/resistant dermatoses

- **History:** Atopy, allergies (jewelry, perfume, hair dye, meds), metabolic syndrome, autoimmune.
- **CINE:** Cutaneous-immune-neuro-endocrine system.
- Bovine milk/high sugar → mTORC overactivation → Suppress FoxO1/SIRT1 → Pro-inflammatory/hyperproliferative (acne, psoriasis, AD, obesity, cancer).
- **Milk:** Lactational genome/species-specific → Immune upregulation → Epigenetic NF-κB → Disease.
- **FoxO1:** Brake on mTOR.
- **All patients:** Metabolic profile (insulin resistance links: acne, psoriasis, AN, alopecia).
- Low glycemic/low dairy early (teen acne prevents metabolic damage).
- Metabolic stress → Leaky gut → Inflammation; low glucose ↓ pro-inflammatory mediators.
- Patch test chronic allergic dermatitis (nickel, cobalt, fragrance); low-nickel diet.
- **Palmoplantar:** Rule out nickel/cobalt/chromate.
- **Systemic contact dermatitis:** Dietary (metals, Compositae, Balsam of Peru, preservatives); elimination diet.
- **Ayurvedics:** Compositae (cabbage, radish → CD).
- Nickel ↑ TSLP → ↑ TNF-α.
- **Compromised barrier (atopy):** Careful topicals (vulnerable to sensitization → SCD).
  Dr. C R Srinivas
- Over-restriction → Malnutrition.
- **Cochrane:** No role diet restriction in AD; prick test avoidance helps.

Session 8: Approach to Suspected Vasculitis

MODERATOR

Dr. Shekhar Neema

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| Initial workup

- CBC/ESR/CRP, urine R/M, BP, viral markers, skin Bx, ANA, RA, ANCA, complement.

| Stepwise approach

1. Vasculitis vs. vasculopathy.
2. Systemic association.
3. Primary vs. secondary.
4. Management.

| Vasculitis mimics (purpura/necrosis/livedo without vessel inflammation)

- **Mechanical:** PPD, senile purpura.
- **Vaso-occlusive:** Calciphylaxis, APLA, livedoid vasculopathy, cholesterol emboli.
- **ITP:** Wet purpura clue.
- Pinch purpura; livedo racemosa; retiform purpura (rule out meningococcemia).
- **Scrub typhus:** SVV/medium vessel vasculopathy.
- **RA:** Waldenstrom/macroglobulinemia.
- **Indian tick typhus:** No eschar; palm/sole vasculitis; serology unreliable; skin Bx IHC.

| IgA vasculitis: Children vs. adults

Feature	Pediatric	Adult
Spontaneous resolution	94% (self-limiting)	89%
Renal involvement	20-55% (mild)	45-85% (severe)
ESRD risk	<1%	10-32%
Relapse	2-30%	Lower, but severe
Triggers	Infection (75%)	Drugs, malignancy, comorbidities
Mortality	Rare (<1%)	Higher (CVD/ sepsis/cancer)

- Screen renal; biweekly URE/BP ×2 months, then monthly.
- **HSP:** Epididymitis/orchitis (mimics torsion); not same as IgA nephropathy.

| Secondary vasculitis causes

- **Infections:** Bacterial (endocarditis, meningococcal), viral (HBV/HCV), fungal/rickettsial.
- **Drugs:** Antibiotics, NSAIDs, checkpoint inhibitors.
- **AICTD:** SLE, rheumatoid.
- **Paraneoplastic:** Lymphoma/leukemia/solid tumors.

| Cryoglobulinemic vasculitis

- Gangrene toes (palpable pulses, no systemic Sx) → Rituximab + steroid.
- Doppler/coags normal; HCV RNA, RA, cryoglobulins.
- **Treatment:** Antivirals + rituximab.
- **Meltzer's triad:** Palpable purpura, arthralgia, weakness.

| Other

- **ENL (resistant):** TNF-α inhibitors (etanercept > infliximab).
- **Thalidomide:** Steroid-sparing.

Session 9: Managing Sepsis in Dermatological Indications

PRESENTER

Dr. Laxmisha

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| Sepsis in autoimmune bullous dermatoses (AIBD)

- 40% deaths from sepsis (skin barrier breach + immunosuppression).
- **Early:** Cultures, serum lactate, procalcitonin (better than CRP).
- **Procalcitonin trend:**
- **Rising:** Infection.
- **Falling:** Antibiotic response.
- q24h.
- **Negative cultures + fever:** Fungal/viral/autoimmune/drug.
- **Empirical Abx (hospital stewardship):**
- **MRSA:** Vancomycin/teicoplanin.
- **Pseudomonas:** Piptaz 4.5 g IV over 4h.
- **Complicated:** Aminoglycosides/ceftazidime.
- **A. baumannii:** Imipenem/meropenem.

| Managing immunosuppressives in sepsis

- **Steroids:** Don't stop abruptly; hydrocort ≤200 mg/day.
- Withhold steroid-sparers (AZA, MMF).

| SOFA-2 score (2025 guidelines)

Take-home:

- Treat sepsis first (more life-threatening than flares; flares wait 24h).
- PCT best friend.
- **Low C3/C4 + rising dsDNA:** Lupus activity.
- Culture everything (blood/urine/pus/wounds).
- Pred >20 mg blunts CRP, masks infection.
- **Therapeutic steroid trial:** Response by 48h differentiates.

Session 10: Genital Dermatoses

PRESENTERS

Dr. Nina Madnani

Dr Niti Khunger

Dr Somesh Gupta

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| Vulvar GPA

- Very rare.

| Cutaneous Crohn's

- Screen stool calprotectin; systemic CD can follow.

| Chancroid

- Do PCR.

| Rising genital HSV-1

- Immunity gap; orogenital sex; asymptomatic oral shedding.
- Stop IgM HSV-1/2 (no value); IgG for past infection.

| Mondor's disease of penis

- Circumferential rod-like sensation; self-limiting.

| Genital warts facts

- 30% resolve by 4 months.
- Recurrence rule (even post-treatment).
- **Factors:** Health, immunity, HPV vaccine, strain, inoculation #, viral load, condoms, co-STI.
- **HPV genotyping:** Risk/recurrence; 16 highest malignancy; 31/18/33 intermediate; 52/58/45 moderate.
- **Recalcitrant:** Typing + colposcopy + 2y F/U + vaccination.
- **Intravaginal:** I/L cryo.

Session 11: Vitiligo Cocktail Therapy

PRESENTER

Dr. C R Srinivas

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- **Irregular F/U:** Combo surgery (NBUVB/excimer + fractional CO2 → GFC → topical triamcinolone).

Session 12: JAK Inhibitors

PRESENTER

Dr. Anand Nott

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- High-dose JAK-1 → JAK-2 inhibition (serious S/E).
- **CSVV:** Dapsone/colchicine.
- **Oral LP:** Cyclosporine; oral steroids + MTX; tofacitinib; metronidazole.
- **Etanercept:** Pediatric pustular psoriasis.
- **Acitretin:** Rapid in pustular psoriasis (slow in others).
- **Tofacitinib:** BD > XR OD; causes acneiform.
- **LPP:** MMF ×3 months → taper ×6 months → pico laser.
- **LPP activity:** Clinical/dermoscopic; HPE clues (p/v small melanophages stage 2; BCD + large stage late).
- **Etanercept SJS/TEN:** 50 mg SC stat → repeat d3 (100h to skin).
- **IVIG SJS/TEN:** If infection.
- **PLC:** MTX, soak/bucket PUVA, phototherapy.
- **Lichen planopilaris:** Oral steroids/minoxidil.
- **Pioglitazone:** Palmoplantar psoriasis.

Session 13: Patient Education

PRESENTER

Dr. Abhay Martin

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- Infographics for pathogenesis/procedures.
- **Toilet seat dermatitis:** Cotton inner-thigh pants (↓ friction); seat covers.
- **Intertrigo:** Avoid V-shaped inners; Castellani paint.
- **Topicals video:** Affected area only; amount.
- **Whitfield's ointment:** Tinea advancing edge.

Session 14: Clues to CTD

PRESENTER

Dr. Seetharam

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When to suspect APLA

- 40% SLE; non-inflammatory retiform purpura; deep necrotic ulcers (livedoid); digital gangrene; subungual splinter; thrombotic H/O; spontaneous abortion.

Monogenic lupus

- Onset <5y; strong F/H; severe skin/neuro/joint; chilblain; male; refractory.

Persistent scalp pruritus

- Scleroderma/dermatomyositis.
- Calcinosis cutis: Diltiazem/sodium thiosulfate.

R/C angioedema (non-responsive)

- ANA.

Consanguinity

- PID/complement/IgA/IgM deficiency (even no F/H); monogenic lupus.

Drug-induced DM

- Statins (simvastatin, lovastatin, atorvastatin); hydroxyurea; checkpoint/TNF-α inhibitors.
- **Hypothyroidism:** Dyslipidemia/myopathy.

| En coup de sabre systemic

- **Contrast MRI:** CNS (seizures/headache), ocular (uveitis), dental.

| Pigmented LE/DM

- ANA-neg, dsDNA+; misdiagnosed as LPP; always ANA.
- dsDNA yearly for activity.

| Uncommon presentations

- **SLE:** Angioedema/TEN/Rowell/monogenic.
- **DM:** Calcinosis/statin/bulbar.
- **Morphea:** Linear/hepatitis/en coup de sabre + CNS.
- Juvenile vs. adult morphea: Deeper/extracutaneous; higher relapse/long active disease.

Session 15: Navigating Biologics

MODERATOR

Dr Brijesh Nair

Session 15 Faculty -
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- Informed consent-Must
- **How to Convince:** tell disease severity , not responding to conventionals, DLQI
- Less organ toxicity (rare cytopenia/hepatotoxicity in TNF-i).
- **Biosimilars:** Same S/E profile.

| Advantages

- Drug survival, efficacy, organ protection, metabolic neutral, compliance.

| Omalizumab

- Highest OPD biologic anaphylaxis risk; crash cart; observe 2h.
- Omalizumab
- ○ Highest risk of delayed anaphylaxis (up to 24 hrs)

| Biologics in psoriasis

- **Indications:** Moderate-severe; palmoplantar/scalp; conventional failure; comorbidities.
- **Choice:** IL-17 (rapid); IL-23 (long interval).
- **Avoid IL-17:** IBD.
- **Practical:** First-line OK; +MTX (↑ TNF survival); avoid CyA/JAKi combos.
- **Safety:** Consent; observe first dose (SC 30 min, IV longer).
- **Tapering:** No washout (modern); increase interval or switch class.
- Biologics which can be tapered

- Secukinumab 300 mg-150 mg (do not taper secukinumab in PsA)
- In biological naïve patients - no induction is required
- Etanercept monthly once (biosimilar) cheaper alternative than cyclosporine
- Wash out period while switching biologicals
- If switching because of A/E -wash out period required
- If switching due to inefficacy - no washout required
- For conventionals wait for 4 T $^{1}/^{2}$
- When to taper / reduce dose (increase the gap rather than reduce the dose)
- As and when required basis for etanercept, secukinumab and ixekizumab
- With adalimumab and infliximab -chance of immunogenicity

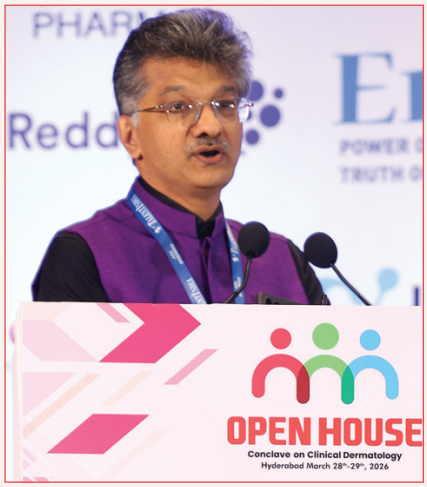
| SJS/TEN

- Cyclosporine > steroids.
- **Etanercept:** Early.
- **IVIG:** Pediatrics; OK post-72h; prefer if sepsis.

Session 16: Trichostories

PRESENTER

Dr. Murugu Sundaram



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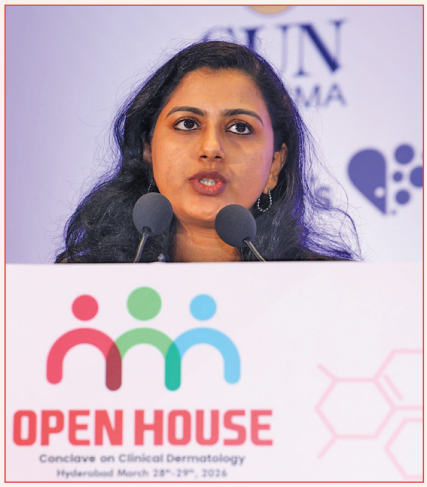
1. **Scurvy:** Corkscrew/twisted/lightly coiled/swan-neck hair (esp. extremities).
2. **Trichotillomania:** Stress-induced.
3. **AA incognito:** Diffuse loss; dermoscopy white dots, dysplastic (burnt matchstick).

Session 17: Uncommon Side Effects of Common Drugs

PRESENTER

Dr. Nimitha



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| Antifungals

- **Itraconazole:** Negative inotrope; high-dose pseudoaldosteronism; vaginal bleeding; acute generalized exanthematous pustulosis; SDRIFE.
- **Fluconazole:** High/daily → telogen effluvium; FDE.
- **Griseofulvin:** Photosensitizing/phototoxic; exacerbates SLE.
- **Terbinafine:** Unmasks SCLE; AGEP; photosensitivity; sensory disturbances.

| Others

- **Minocycline:** Lupus; hyperpigmentation; DRESS.
- **Acitretin:** Capillary leak; differentiation syndrome.
- **Isotretinoin:** ↓ Sleep (psychotic mania risk); pseudotumor cerebri (with tetracyclines); thrombocytopenia.
- **Cyclosporine:** PRES; paradoxical folliculitis.
- **MTX:** Accelerated nodulosis (tender firm nodules like RA SC nodules, away from joints).
- **Glutathione:** IV unregulated → AKI; chronic → zinc depletion/ hair greying/pedal edema.
- **Dapsone:** Agranulocytosis; pure motor neuropathy.
- **Apremilast:** Psychiatric exacerbation; weight loss.
- **JAKi:** CVS risk, lymphoma, weight gain, acne.
- **Colchicine:** Myoneuropathy, azoospermia; avoid statin/ macrolide.

- **Tranexamic acid:** Seizures, dyschromatopsia.
- **HCQ:** Restrictive cardiomyopathy, retinal/ototoxicity.
- **Antihistamines:** FDE; intractable pruritus on withdrawal.
- **Finasteride:** PFS; orthostatic hypotension.
- **IL-17:** IBD; recurrent mucocutaneous fungal.
- **Topicals:**
- **Minoxidil:** Liver injury.
- **Azelaic acid:** Asthma.
- **BPO:** Hypopigmentation.
- **Selenium sulfide:** Orange discoloration; lactation suppression.
- **TCI:** Neurovascular flush + alcohol.

Session 18: Hidradenitis Suppurativa

PRESENTERS

Dr. Somesh Gupta

Dr Niti Khunger

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OH Hyderabad 2026

- **Risk:** Obesity, smoking.
- **Stages:** 1 (non-scarring); 2 (scarring discrete); 3 (scarring coalescing).
- Not apocrine; hair follicle disease.
- **Always:** Laser hair reduction.
- **Retinoids:** Follicular occlusion triad only.
- Tetra 500 mg QID best but least tolerated.
- Clinda + Rifampicin 300 mg BD ×3 months (preferred).
- Linezolid 600 mg OD ×10-12 weeks (watch pancytopenia).
- **Tofa:** Majority worsens.
- Adalimumab weekly best biologic.
- **ILS:** Acute flares only.
- **General:** Anemia correction, ↓ smoking, diet/weight.
- **Best:** Biologics + surgery (adalimumab + Sx; infiltrate TXA peripherally ↓ bleeding).
- **All patients:** Hurley staging, IHS4 score.
- **Post-Sx:** Recurrence common but milder severity.

| Dr. Niti: 5 phenotypic domains

1. **Inflammatory:** NSAID, doxy, apremilast, Tofa, colchicine, biologics.
2. **Sinus/scarring:** Procedures.
3. **Follicular/acneiform:** Isotret, LHR.
4. **Metabolic:** Weight reduction, myoinositol, metformin, GLP-1 agonist.

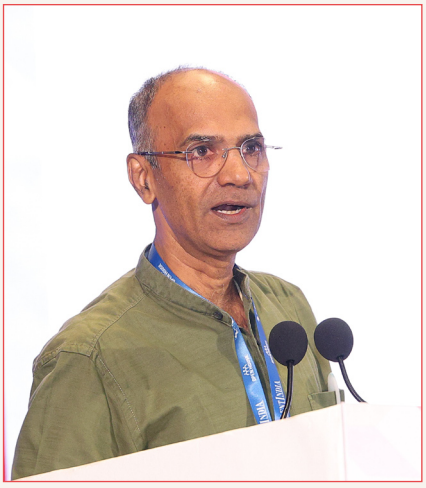
5. **Syndromic/autoinflammatory:** Apremilast, Tofa, upadacitinib, colchicine, steroid.

- **Imaging pre-Sx:** USG/MRI.
- **Nodules:** ILS + anti-inflammatory.
- **Abscess:** Drain + ILS + genta.
- **Sinus:** Phenolize, MB-PDT → deroofing.
- **Phenolization:** USG tract; 88% phenol toothpick 1-2 min; NS irrigate.
- **MB-PDT:** Post-phenol; 1% MB inject/topical; LED red 15 min weekly → ↓ discharge.
- **Fibrosis:** CO2/RF deroofing.

Session 19: Oral Cavity Conundrums

PRESENTERS

Dr. Anand Nott



Dr. Vijay Karthik

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| LP subtypes

- Reticular, erosive/ulcerative, atrophic, papular, plaque, bullous.
- Biopsy before steroids/ILTA.

| Oral LP

- Post-checkpoint (pembrolizumab): Bullous/lichenoid → acitretin.
- Cinnamon lip balms ↑ risk.
- **SCC risk:** Alcohol/smoking/ulcerative-atrophic/HCV/ syphilis/sharp teeth.
- Always biopsy (miss lichenoid dysplasia).
- Smoker lichenoid: Biopsy hyperplastic mucosa → malignancy risk.

| Desquamative gingivitis

- **Rule out:** Pemphigus, pemphigoid, plasma cell gingivitis, LP.
- **BP/oral LP:** MTX works well.

| Red flags

- Long-standing → Dysplasia risk.
- Poor hygiene worsens.

| Evaluation (5 S)

- HCV screen.
- **Irritants:** Sharp teeth, syphilis, septic (HCV), spirit, spices (betel/cinnamon).
- **Dental:** Acrylate/resin, titanium exacerbate.

| Patch test

- No role in mucosal (skin only).

| Malignant transformation

- **MC:** Alcohol/HCV/smokers.

| Biopsy pearls

- Always biopsy (symptomatic/asymptomatic);
- Avoid cheek bite area

- **LP:** Lace pattern (parakeratosis).
- **DIF LP:** Shaggy fibrinogen, no Ig.
- **Technique:** Before taking biopsy of oral leukoplakia give metronidazole and fluconazole for 2 weeks to treat oral flora- gives better yield, LP can also respond to metronidazole
- biopsy technique -use insulin syringe to give anaesthesia then use a 4 mm punch and spear the biopsy with the same insulin needle to lift it up and cut from base. after taking the tissue use a gauze to press against biopsy site and ask patient to clench their teeth to achieve hemostasis. avoid hot beverages for 30 mins
- Drug-induced LP
- Antihypertensives (BB, ACEI, ARB), HCQ, TNF-α inh, metformin, imatinib, checkpoint inh.

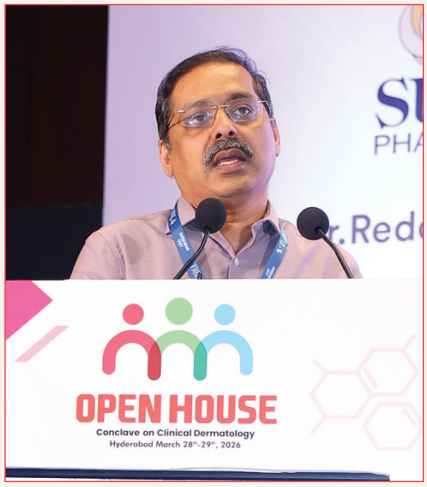
Granulomatous cheilitis

- Trauma/lip bite.
- ILCS, minocycline, metro gel.
- **Or:** Azithromycin pulse (weekly ×3 ×8 weeks) + I/L steroid.
- Static 3-4 months → Lip reduction Sx.

Session 20: Legal Conundrums

PRESENTER

Dr. Abhay Martin



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- Reply consistently; no negotiation.
- Careful with recordings.
- Summons: Don't panic (defend opportunity).
- Approach legally only.
- ADR ≠ off-label/negligence.
- Follow authorized guidelines.
- Document indemnity insurance (IMA; include procedural derm).
- Seek legal help for notice.
- **1st response:** Carefully drafted (no later change).
- Pre/post photos + written consent mandatory for procedures.
- **Drug reaction:** Document management.
- **Clinic:** Crash cart; MOU local hospital.
- **Technician procedures:** Train, quality check, liability.

Lecture 21: Pustular Dermatoses

PRESENTER

Dr. Soumya

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- ETN vs. oil folliculitis: Oil → intervening skin normal.

| Open House Pearls

1. **Peribuccal pigmentation:** Rule out IDA/zinc deficiency.
2. **Telogen effluvium:** Topical steroid 1 week on/off; avoid minoxidil shedding phase (6-8 weeks).
3. **Formaldehyde hyperhidrosis:** Later ACD risk.

- **Macular amyloidosis:** Colchicine/HCQ.
- **Lichen amyloidosis:** Acitretin/tazarotene/fractional CO2.
- **Acral peeling:** Fingerprint loss → ID certification.
- **Cyclosporine S/E:** Hypomagnesemia → Arrhythmias.
- **Trichoteiromania:** Eyebrow/eyelash rubbing (subconscious).
- **Oral minoxidil:** Hypertrichosis reversible.
- **Neonatal cephalic pustulosis:** Ketoconazole.
- **Candidiasis:** Fluconazole (3-6 mg/kg) + topical.
- **HFMD:** Viral (RNA) → No acyclovir.
- **Pityriasis rosea:** Acyclovir variable (some strains).
- **CSU urticaria workup:** H. pylori, dental, UTI, GI.
- **Tx:** 2× nonsedating + 1× sedating H1.
- IgE <47 → Cyclosporine; =47 → Omalizumab.
- **Histaglobulin:** Trial (placebo-like).
- **Remibrutinib:** Emerging.
- **Tinea:** Moisturizer + 20% SA.

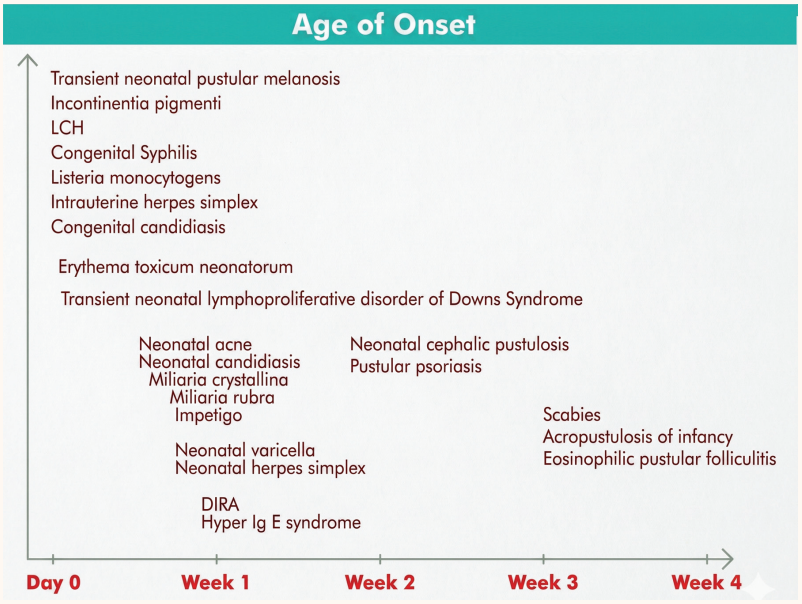
Common neonatal pustular dermatoses

Condition	Timing	Characteristics	Management
Erythema Toxicum Neonatorum (ETN)	24-48 hrs after birth (rarely at birth)	Blotchy red macules with central yellow/white pustules. Common (up to 75% of term neonates).	Benign; resolves spontaneously in 7-14 days.
Transient Neonatal Pustular Melanosis (TNPM)	Present at birth or first few days	Small superficial pustules without surrounding redness (erythema). Leaves pigmented macules.	Benign; self-limiting.

Miliaria Pustulosa	Within first week(s)	Clustered pustules on red patches, often on trunk/ axillary region (due to sweat duct obstruction).	Keep cool, avoid excessive clothing.
Neonatal Cephalic Pustulosis (Neonatal Acne)	First few weeks	Pustules/papules on face, scalp, neck. Often linked to Malassezia species.	Usually none; sometimes topical antifungals (e.g., ketoconazole).
Neonatal Candidiasis	First few days	Erythematous papules/ pustules, often in diaper/ skin folds.	Topical or systemic antifungal therapy.
Neonatal Herpes Simplex (HSV)	5-14 days	Clustered, fragile vesicles/ pustules on red base. Often vesicles become pustular.	Urgent antiviral therapy; potentially fatal.

Classification according to age of onset

REF: Afra T, Daroach M, Mahajan R, De D, Handa S. Pustular lesions in the neonate: Focused diagnostic approach based on clinical clues. Indian J Dermatol Venereol Leprol 2022;88:708-16.



Generalised pustular psoriasis- Cyclosporine, IL-17 blockers (infliximab too) for immediate onset of action, retinoids for long term control.

S/c methotrexate a good option for faster control.

SCPD vs GPP vs Ig A pemphigus- need clinicopathological correlation.

T capitis can present as pustules on scalp, often overlooked.

Folliculitis decalvans presents with superficial pustules and tufted folliculitis while dissecting cellulitis has deeper involvement with boggy swellings, nodules and sinus tracts. FD has association with Staph aureus while Dissecting cellulitis associated with the follicular occlusion tetrad. Both require long term antibiotics/ isotretinoin and sometimes surgical management.

Palmoplantar pustulosis- can be drug induced too. Retinoids , apremilast may also work well.

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