Highlights

1 Erythroderma - a retrospective study with special emphasis on good prognostic factors

7 Acne - experiences from Can Tho, Vietnam

18 Syphilis - atypical presentation

21 Primary Cutaneous Anaplastic Large Cell Lymphoma

29 Dermatology Achievements in the 1st decade of the millennium

Bull dog skin

Watch out for this

Test your CPC skill
Editorial

In the first decade of 21st Century, under the stewardship of Dr. Stevens Chow Kim Wing, Asian Academy of Dermatology & Venereology was formed with members consisted of senior dermatologists from Asian countries.

Dr Henry Foong established an International Virtual Grand Round in Dermatology in 2000 which is a web based global dermatology network and gathering place for dermatologists. The Malaysian Dermatological Society website was created by Dr Allan Yee in 2006 and is located at www.dermatology.org.my. This website has facilitated rapid communication among members.

In the century too, Advance Masters course in Dermatology was set up in Universiti Kebangsaan Malaysia which is the brainchild of Puan Sri Dr Suraiya Hani Hussein. The move towards upgrading of post-graduate training has resulted in trainees coming up with thesis and writing original scientific articles.

The training on use of Dermatology terminology to describe skin sign was introduced to primary care providers to facilitate communication between clinicians and also with the paramedics. The introduction of Dermatology nursing care training to non-dermatology nursing personnel at primary and secondary care levels have enabled patients to receive basic skin nursing at first encounter. Another Malaysian First is when 2 nurses wrote their thesis in Dermatology nursing care at nursing degree course in the local University.

On November 2010, Malaysian Journal of Dermatology which was started in 1987 has been accepted in West Pacific Region Index Medicus (WPRIM). This enables Asian scientific papers to be viewed in the net and knowledge shared with our counterparts in other countries.

Editor in Chief
Malaysian Journal of Dermatology
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Contributions should be written for one of the following categories:

Case Report* A report of 400-600 words, illustrated by no more than three illustrations. This category offers a means for rapid communication about a single subject.

Clinical Trial An article of 700-1200 words concerning a drug evaluation. This category provides rapid publications and is meant to be a succinct presentation with a minimum of graphs and tables.

Commentary* An editorial 700-1200 words in length with approximately five references. The author may express his or her opinion without complete documentation.

Clinicopathological Challenge A photographic essay that includes both clinical and pathological photographs in color. The diagnosis and legends for the photographs should be listed after the references in the article. The article should be no more than 2-3 pages in length.

Correspondence* Letters to the editor and short notes. Contributions should not exceed 600 words, two figures, and 10 references.

Dermatological Surgery An article relating to the surgical aspects of treatment. Article types may include Review, Report or Case Report Format.

Original Article An original article including, whenever possible, an Introduction, Materials and Methods, Results, Comment, and References. A Structured Abstract of not more than 240 words must be included. It should consist of four paragraphs, labelled Background, Methods, Results, and Conclusions. It should describe the problem studies, how the study was performed, the main results, and what the author(s) concluded from the results.

Review By invitation only. A major didactic article that clarifies and summarizes the existing knowledge in a particular field. It should not be an exhaustive review of the literature, and references should not exceed 100 in number. Tables, diagrams, and selected figures are often helpful. The length is left to the judgment of the author, although it generally should not exceed 5000 words. Topics may include updates in clinically relevant basic science and cutaneous biology.

Manuscripts should include a title page bearing the title of the paper, the author(s)' name(s), degrees, and affiliation(s), the category of the article, the number of figures and tables, and three key words for indexing purposes. The name and full postal address (including a street address), phone and fax numbers and an email address of the corresponding author who will be responsible for reading the proofs must also be given on the title page. The author(s) must also declare any affiliation or significant financial involvement in any organizations or entity with a direct financial interest in the subject matter or materials discussed in the manuscript on this page.

All measurements should be according to the metric system. If confusion could result, please include other measurement systems in parentheses.

Refer to patients by number or letters; names or initials should not be used.

References must be listed in the order in which they appear in the manuscript. References from journals should include: (1) name(s) followed by the initials of the author(s), up to four authors; if more than four authors, include the first three authors followed by et al.; (2) title of paper; (3) title of the journal as abbreviated in the Index Medicus; (4) year of publication; (5) volume number; (6) first and final page numbers of the article.

For example:

References to books should include: (1) author(s) or editor(s); (2) chapter (if any) book titles; (3) edition, volume, etc.; (4) place of publication; (5) publisher; (6) year; (7) page(s) referred to.

For example:

The author is responsible for the accuracy and completeness of all references; incomplete references may result in a delay to publication.

Tables should be typed, double-spaced with a heading, each on a separate sheet, and should only include essential information. Drawings, graphs, and formulas should be submitted on separate pages.

Send illustrations as tiff or jpeg files. In the case of photomicrographs, the stain type and original magnification should be stated. Each figure should bear a reference number corresponding to a similar number in the text.

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*No abstract required
Contents

GENERAL DERMATOLOGY

Original Article
1 Erythroderma - a retrospective study with special emphasis on good prognostic factors
Peter C, MBBS, Adam B, Rohna R, MRCP

7 Clinical and related factors in acne - experiences from Can Tho, Viet Nam
Tran Thi Hanh

12 Adequacy of care in patient with psoriasis (ADECAP) Study
Tan WC, Chan LC, Ong KP, et al

Case Reports
18 Syphilis - the great mimicker
Su-ning W, MRCP, Moonyza AAK, MD, Dawn A, MRCP et al

21 Primary Cutaneous Anaplastic Large Cell Lymphoma: Report of 3 cases from Hospital Kuala Lumpur

Short Communication
25 Cutis verticis gyrata secondary to congenital melanocytic naevus - a case report
Vinitha VP, MD, Dhamramaratnam AD, MD, Joel Karuvilla P, MD.

27 CLINICOPATHOLOGICAL CHALLENGE
Dawn A, Lee BR, Latifah

SNIPPETS ON MALAYSIAN DERMATOLOGY DEVELOPMENT IN THE 1ST DECADE OF THE MILLENIUM

29 Asian Academy of Dermatology & Venereology
Steven Chow KW

31 Malaysian Dermatological Society’s Internet Milestones
Henry FBB

32 Dermatology Training in Malaysia
Suraiya HH

CONTINUOUS MEDICAL EDUCATION

34 Advance Masters in Dermatology

36 Malaysian Dermatology Congress & AGM

36 Asia Pacific Environmental & Occupational Dermatology Symposium

37 Malaysia participation in 22nd World Congress of Dermatology

37 Book Review

OBITUARY

38 Allan

39 Adam
Erythroderma - A retrospective study with special emphasis on good prognosis
Peter Ch’ng WB1, MRCP, Adam B2, Rohna R1, MRCP

Abstract

Background  Erythroderma is a serious condition in itself, quite apart from hazards associated with the underlying disease, and is sometimes fatal. Prognostic studies are rare in the literature and to date there are no published studies to identify the factors that can determine good prognosis.

Objectives  The aim of the study is to determine the factors that can prognosticate the good outcome of erythroderma.

Methodology  Cross sectional study from patients diagnosed to have erythroderma between 2003 and 2007 were analyzed with regard to age, sex, race, underlying medical illness, aetiology, duration of rash before diagnosis of erythroderma, response to topical therapy and prognosis.

Results  Four variables (aetiology, gender, duration of rash before being diagnosed as erythroderma and response to topical therapy) were associated with good prognosis. These variables were statistically significant from univariate analysis. When these variables were included into the binary logistic model, the study did not have enough evidence to proof that ‘aetiology’ and ‘gender’ can determine good prognosis. Response to topical therapy and shorter duration of rash (equal and less than 120 days) were significant with odds ratio (CI) of 4.11 (1.556, 10.885) and 4.608 (1.903, 11.155) respectively.

Conclusion  Shorter duration of rash and response to topical therapy are important factors to determine a good prognosis.

Keywords  exfoliative dermatitis, generalised erythema, outcome

Introduction  Erythroderma also known as generalized exfoliative dermatitis is characterized by erythema affecting more than 90% of the body surface area accompanied by a variable degree of scaling1.

Erythroderma is a serious condition in itself, besides hazards associated with the underlying disease, and is sometimes fatal despite skilled management. It is particularly dangerous in elderly people. Reported death rates have varied from 18 to 64%,2-4 but with modern therapy the rate is probably lower.

Prognostic studies are rare in the literature and to date there are no published studies to identify the factors that can determine good prognosis5-10.

This is important when informing the patient or family members regarding the prognosis of the patient. Hence the aim of the study is to determine the factors that can prognosticate the good outcome
of erythroderma. Furthermore, we also looked at various clinical data of these patients to have a better understanding of the disease.

**Materials and methods**

A cross sectional study of patients diagnosed with erythroderma, in local Hospital between 2003 and 2007, were analyzed. The information was collected from the patients' records and included age, sex, race, underlying medical illness, aetiology, duration of erythroderma, response to topical therapy and prognosis. Idiopathic erythroderma will only be considered if other aetiology had been ruled out and a skin biopsy has been done for the patient.

We defined poor prognosis as having relapse, persistent erythroderma or death and good prognosis as having complete or partial resolution of erythroderma. Partial resolution of erythroderma is defined as erythema affecting less than 90% of the body surface area.

**Statistical method**

The analysis was carried out using PASW 18.0. Categorical variable were reported in frequency with percentage and numerical variable were reported in median and inter quartile range (IQR). Appropriate statistical test was used after considered statistical assumption to determine the association between selected risk factors towards bad or good prognosis. The statistical tests used were Chi square test, Fisher exact test and Mann Whitney U test. Binary logistic regression was used to test the risk factors simultaneously using stepwise with Backward Likelihood Ratio method and removal item procedure used was 0.50. The P-value and Odds ratio with confidence interval were reported to determine the strength of factors that can prognosticate the good outcome of erythroderma.

**Results**

**Prognosis**

5 out of the 124 patients who had missing data or defaulted follow up, were excluded in the analysis. 82 out of 119 patients (68.9%), had good prognosis while 37 (31.1%) had poor prognosis. 13 patients had died and none of the patients, the immediate cause of death was directly related to erythroderma. 4 patients died during hospital admission for erythroderma of which 2 died of acute coronary syndrome, 1 sudden death and 1 multi-organ failure. Of the 9 patients whose death was during the study period but not during the admission for erythroderma, one died of advanced stomach carcinoma, another died of organophosphate poisoning while the cause for the other 7 were attributed to sepsis. As for the aetiology of erythroderma among those who died, 5 patients were idiopathic, 4 patients were having psoriasis and 4 were due to drugs.

Four variables (gender, duration of rash before being diagnosed as erythroderma, response to topical therapy and aetiology) were associated with good prognosis. These 4 variables were statistically significant from univariate analysis. (Table 1) When these 4 variables were included into the binary logistic model, the Nagelkerke R square was acceptable (0.322) but the analysis did not have enough evidence to prove that ‘aetiology’ and ‘gender’ can determine good prognosis.

This study has enough evidence to prove that response to topical therapy and shorter duration of rash (equal and less than 120 days) were significant with odds ratio (CI) of 4.116 (1.556, 10.885) and 4.608 (1.903, 11.155) respectively. The difference between the median for duration of rash before being diagnosed as erythroderma in days for bad and good prognosis were 120 days and 25.5 days respectively.

Patients who responded to topical therapy are 4.1 times more likely to have good prognosis compared to those patients who did not respond to topical therapy. Those with shorter duration of rash (equal and less than 120 days) were 4.6 times more likely to have good prognosis compared to those patients with longer duration (more than 120 days) of rash.

However for ‘aetiology’, the strength of odds ratio does exist especially for ‘drug induced’ (P value = 0.493, OR = 1.665, CI = 0.387, 7.169) and ‘contact dermatitis’ (P value = 0.207, OR = 5.262, CI = 0.399, 69.443) as compared to ‘idiopathic erythroderma’. Besides that, Female also has the impact on good prognosis (P value = 0.217, OR = 1.953, CI = 0.675, 5.646)

**Clinical data**

Majority (46%, n=57) of the patients were more than 60 years old. 78 (63%) were male and 46 (37%) were female. More than half of our patients were Malays followed by Chinese, Indian and others. (Table 1) As for the underlying medical illness, 26 (21%) had diabetes mellitus, 47 (37.9%) had hypertension and 18 (12.9%) had ischaemic heart disease.
Table 1 Profile of patients with guarded and good prognosis

<table>
<thead>
<tr>
<th>Profiles</th>
<th>Guarded prognosis</th>
<th>Good prognosis</th>
<th>Overall ****</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age Group (yrs)</strong></td>
<td></td>
<td></td>
<td></td>
<td>0.711 *</td>
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<tr>
<td>&lt;1</td>
<td>0 (0.0)</td>
<td>3 (100.0)</td>
<td>5 (4.0)</td>
<td></td>
</tr>
<tr>
<td>1-20</td>
<td>2 (20.0)</td>
<td>8 (80.0)</td>
<td>10 (8.1)</td>
<td></td>
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<tr>
<td>21-40</td>
<td>6 (33.3)</td>
<td>12 (66.7)</td>
<td>18 (14.5)</td>
<td></td>
</tr>
<tr>
<td>41-60</td>
<td>13 (38.2)</td>
<td>21 (61.8)</td>
<td>34 (27.4)</td>
<td></td>
</tr>
<tr>
<td>&gt;60</td>
<td>16 (29.6)</td>
<td>38 (70.4)</td>
<td>57 (46.0)</td>
<td></td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
<td>0.014</td>
</tr>
<tr>
<td>Male</td>
<td>29 (39.2)</td>
<td>45 (60.8)</td>
<td>78 (62.9)</td>
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<tr>
<td>Female</td>
<td>8 (17.8)</td>
<td>37 (82.2)</td>
<td>46 (37.1)</td>
<td></td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
<td></td>
<td></td>
<td>0.324 *</td>
</tr>
<tr>
<td>Malay</td>
<td>18 (26.1)</td>
<td>51 (73.9)</td>
<td>71 (57.3)</td>
<td></td>
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<tr>
<td>Chinese</td>
<td>14 (35.0)</td>
<td>26 (65.0)</td>
<td>42 (33.9)</td>
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</tr>
<tr>
<td>Indian</td>
<td>4 (50.0)</td>
<td>4 (50.0)</td>
<td>9 (7.3)</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>1 (50.0)</td>
<td>1 (50.0)</td>
<td>2 (1.6)</td>
<td></td>
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<tr>
<td><strong>Status of DM</strong></td>
<td></td>
<td></td>
<td></td>
<td>0.318</td>
</tr>
<tr>
<td>Yes</td>
<td>6 (23.1)</td>
<td>20 (76.9)</td>
<td>26 (21.0)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>31 (33.3)</td>
<td>62 (66.7)</td>
<td>98 (79.0)</td>
<td></td>
</tr>
<tr>
<td><strong>Status of IHD</strong></td>
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<td></td>
<td></td>
<td>0.988</td>
</tr>
<tr>
<td>Yes</td>
<td>5 (31.3)</td>
<td>11 (68.8)</td>
<td>18 (12.9)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>32 (31.1)</td>
<td>71 (68.9)</td>
<td></td>
<td></td>
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<tr>
<td><strong>Status of HPT</strong></td>
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<td></td>
<td></td>
<td>0.596</td>
</tr>
<tr>
<td>Yes</td>
<td>13 (28.3)</td>
<td>33 (71.7)</td>
<td>47 (37.9)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>24 (32.9)</td>
<td>49 (67.1)</td>
<td>77 (62.1)</td>
<td></td>
</tr>
<tr>
<td><strong>Duration of rash (days)</strong></td>
<td>120 (807.3)</td>
<td>25.5 (83.0)</td>
<td>30 (231.5)</td>
<td>0.009 ***</td>
</tr>
<tr>
<td>Duration of rash (days) in category</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>≤120 days</td>
<td>17 (20.5)</td>
<td>66 (79.5)</td>
<td>83 (69.7)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>&gt;120 days</td>
<td>20 (55.6)</td>
<td>16 (44.4)</td>
<td>36 (30.3)</td>
<td></td>
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<tr>
<td><strong>Secondary Infection</strong></td>
<td></td>
<td></td>
<td></td>
<td>0.120</td>
</tr>
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<td>6 (20.0)</td>
<td>24 (80.0)</td>
<td>33 (28.2)</td>
<td></td>
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<tr>
<td>No</td>
<td>29 (35.4)</td>
<td>53 (64.6)</td>
<td>84 (71.8)</td>
<td></td>
</tr>
<tr>
<td><strong>Response to topical</strong></td>
<td></td>
<td></td>
<td></td>
<td>0.001</td>
</tr>
<tr>
<td>Yes</td>
<td>22 (23.7)</td>
<td>71 (76.3)</td>
<td>96 (78.0)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>15 (57.7)</td>
<td>11 (42.3)</td>
<td>27 (22.0)</td>
<td></td>
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<tr>
<td><strong>Aetiology</strong></td>
<td></td>
<td></td>
<td></td>
<td>0.016 *</td>
</tr>
<tr>
<td>Drugs</td>
<td>9 (18.4)</td>
<td>40 (81.6)</td>
<td>49 (39.5)</td>
<td></td>
</tr>
<tr>
<td>Psoriasis</td>
<td>16 (51.6)</td>
<td>15 (48.4)</td>
<td>31 (25.0)</td>
<td></td>
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<tr>
<td>Idiopathic</td>
<td>6 (40.0)</td>
<td>9 (60.0)</td>
<td>17 (13.7)</td>
<td></td>
</tr>
<tr>
<td>Contact</td>
<td>1 (11.1)</td>
<td>8 (88.9)</td>
<td>9 (7.3)</td>
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<tr>
<td>Others</td>
<td>5 (33.3)</td>
<td>10 (66.7)</td>
<td>18 (14.5)</td>
<td></td>
</tr>
</tbody>
</table>

*P-value derived from Fisher’s exact test  **Reported Median (IQR)  ***P-value derived from Mann Whitney U test  ****The size of sample were different in the overall due to missing data
33 (28.2%) of the patients were complicated with secondary bacteria skin infection. 96 (78%) of the patients had resolution of erythroderma with topical therapy whereas 27 (22%) required systemic steroids.

Aetiology
Drugs were the commonest cause of erythroderma, followed by psoriasis, idiopathic, contact dermatitis and others. Out of the 18 causes for others, 6 were due to atopic dermatitis, 6 photocontact dermatitis, 2 ichthyosis, 1 seborrhoeic dermatitis, 1 food, 1 contrast media and 1 due to Werner Syndrome. Among the drugs, antibiotics were the most frequent followed by allopurinol, phenytoin, beta blocker, supplements and analgesic. The commonest cause of contact dermatitis, was liniment followed by cement (Table 1).

Discussion
The prognosis for patients with erythroderma varied in different published studies. Nicolis and Helwig recorded 87 of 108 deaths related to the dermatosis and the dermatosis cleared in only a small number of patients. As for Abrahams et al, 73 out of 101 cases reported recovery and 19 deaths as a complication of erythroderma. Hasan and Jansen reported no death attributed to erythroderma; 17 out of 35 patients (49%) had completely recovered, while another 12 patients (34%) had improved.

Although none of the immediate cause of death in our study was directly related to erythroderma, it is difficult to determine whether the death was due to the complication of erythroderma or due to natural cause. This is because majority of the death in our study was due to sepsis or cardiac complication, which can happen as a complication of erythroderma. On the other hand, most of our patients were more than 60 years old and a proportion of the patients may die of natural cause during the study period.

In our study we not only looked at mortality but we also looked at factors that can prognosticate the good outcome of erythroderma. In our patients, the group associated with the best prognosis was that related to drugs and such findings have been observed in literature.

Besides drugs, contact dermatitis causing erythroderma was associated with good prognosis as compared to idiopathic cause. This is because the aetiology is known and therefore by removing the cause, it will lead to resolution of erythroderma. Where else for idiopathic, it tends to have relapse or being persistent because the main precipitant has yet to be identified. Although none of the patient in our study was diagnosed to have erythroderma secondary to cutaneous lymphoma or other malignancy during the study period, it is possible that some of them may evolve to malignancy later on.

Table 2 Aetiology of erythroderma (N=119)

<table>
<thead>
<tr>
<th>Aetiology</th>
<th>n (%)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antibiotics</td>
<td>11 (22.4%)</td>
<td>49 (39.5%)</td>
</tr>
<tr>
<td>Others</td>
<td>9 (18.4%)</td>
<td></td>
</tr>
<tr>
<td>Unsure Exact Drug</td>
<td>9 (18.4%)</td>
<td></td>
</tr>
<tr>
<td>Allopurinol</td>
<td>8 (16.3%)</td>
<td></td>
</tr>
<tr>
<td>Phenytoin</td>
<td>4 (8.2%)</td>
<td></td>
</tr>
<tr>
<td>Beta Blocker</td>
<td>3 (6.1%)</td>
<td></td>
</tr>
<tr>
<td>Supplements</td>
<td>3 (6.1%)</td>
<td></td>
</tr>
<tr>
<td>Analgesic</td>
<td>2 (4.1%)</td>
<td></td>
</tr>
<tr>
<td>Psoriasis</td>
<td>31 (25%)</td>
<td></td>
</tr>
<tr>
<td>Idiopathic</td>
<td>17 (13.7%)</td>
<td></td>
</tr>
<tr>
<td>Contact Dermatitis</td>
<td>4 (44.4%)</td>
<td>9 (7.3%)</td>
</tr>
<tr>
<td>Liniments</td>
<td>3 (33.3%)</td>
<td></td>
</tr>
<tr>
<td>Cement</td>
<td>2 (22.2%)</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>18 (14.5%)</td>
<td></td>
</tr>
</tbody>
</table>
Shorter duration of rash before being diagnosed to have erythroderma tends to have good prognosis. One possibility is that drugs and contact dermatitis commonly present with a short duration of rash and therefore lead to good prognosis.

Females are 21.4% more likely to have good prognosis than males. It is perhaps due to the small sample size, the test could not detect the difference. A study done by Sigurdsson et al\(^1\) suggested that there is a possibility that women with erythroderma have a better prognosis than men.

Patients who responded to topical therapy were more likely to have a good prognosis compared to those patients who did not respond to topical therapy. This is because patients who have relapses or persistent erythroderma tend to be resistant to topical therapy and require oral steroid.

Majority of our patients were more than 60 years of age which is similar to the study performed by Sigurdsson et al\(^1\) in which the average age of their patients was 61.

As shown in Table 2, aetiologies of erythroderma are rather similar as compare to other series\(^2\)-\(^4\),\(^11\)-\(^17\).

However in our study, there was a significantly larger proportion of erythroderma secondary to adverse drug reaction especially due to antibiotics and allopurinol. This warrants particular attention and may be due to high rate of injudicious prescription of these drugs in Malaysia.

**Conclusion**

Shorter duration of rash and response to topical therapy are important factors that can prognosticate the good outcome of patients with erythroderma. Gender (female) and aetiology (drugs and contact allergen) also have contribution to good prognosis, however due to small sample size, the results were not significant.

**References**

Clinical and related factors in Acne - Experiences from Can Tho, Viet Nam

Tran Thi Hanh

Abstract

Background: Acne is a common disease in teenagers and young adults. This study was conducted to provide physicians with a better understanding of the disease and to improve their advice to patients.

Objective: To define the prevalence of acne, it’s related factors and its psychological impact on the pupils at Chau Van Liem Senior High School.

Method: A cross sectional descriptive study including 405 pupils in 10th, 11th, 12th grades was carried out by means of medical examination, and interviews based on questionnaires.

Results: The prevalence of acne in Chau Van Liem Senior High School pupils is 82.5% overall. Separately, the incidence was slightly higher for boys with 83.9% than girls with 81.7%. Most of these pupils had moderate acne (51.5%), with 46.7% having mild acne. Only 1.8% had the disease at severe. Moderate acne was 1.72 times more common in males than females (p = 0.02, OR = 1.72). The essential lesions included oily skin, comedone, and papules, accompanied with pigmentation and/ or scar. One risk factor associated with acne was identified as the habit of using cosmetics (OR=2.12). The research also identified the differences between boys and girls in their habits related to acne. These included: the concern about acne (p=0.003), facial massage (p=0.02), using facial milk (p=0.001), using cosmetics (p=0.001). Acne led to diffident (p=0.01), depression (p=0.05), and ashamed (p=0.003). Boys with acne were less communicative than girls (p=0.03).

Conclusion: The prevalence of acne in Chau Van Liem Senior High School pupils is 82.5%. Pupils still display bad habits like acne squeezing, applying cosmetics, using mixed-cream bought from the store or self concocted mixtures of locally obtainable creams including steroids, aspirin, antibiotics, vitamins, carelessly applying corticoid-contained medicine which harm their skin. Acne also affects their mental health, emotional well being, and performance in school, family relationships, and friendships.

Keywords Vietnam, adolescence, behaviour, skin lesion

Introduction

Acne vulgaris is a self limited disorder of the pilosebacious unit that is seen primarily in adolescent. This is one of the most common disease, with 85% of all teenagers (18) being affected to some degree. Generally, involution of the disease occurs before age 25.

In prolonged cases, the sequelae can be life long; with pitted hypertrophy scar formation that can cause psychological or emotional harm varies from patient to patient. In Viet Nam, acne is a very common disease, most of the patients here practice self treatment by using cosmetics, using mixed cream bought from the store or self concocted mixtures of locally obtainable creams including steroids, aspirin, antibiotics and vitamins.

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In addition, they take self prescribed medicine, squeeze the affected area, and have facial massage. These types of behaviour worsen acne and form scars. This study was conducted to provide physicians with a better understanding of the disease and to improve their advice to patients.

**Materials and methods**

**Research Design:** Cross-sectional Study

**Subjects/Respondents**
405 pupils in 10th, 11th and 12th grades who were studying from October 2006 to April 2007 and satisfied all the sampling criteria as outline below.

**Inclusion Criteria**
- All the pupils above were studying during the time of data collection
- Appropriate age: Grade 10 (15 years old), Grade 11 (16 years old), Grade 12 (17 years old)
- Consent to participate and be present at school

**Sample**
Until my research, there had not been any study completed showing the prevalence of acne among the pupils in the senior high school here in Viet Nam. Thus, P was defined as 50% to get the maximum sample.

\[
\begin{align*}
    n &= \frac{Z^2_{1-\alpha/2} \cdot P(1-P)}{d^2} = \frac{1.96^2 \times 0.5 \times (1-0.5)}{0.05^2} = 384
\end{align*}
\]

**Sampling process**

*Step 1:* Select Chau Van Liem Senior High School.
*Step 2:* Contact the Head Board to arrange a convenient time for data collection.
*Step 3:* Make a list of pupils under stratifications, Cluster Random Sampling was chosen.

**Data collection:**
Individual interviews were given to complete the survey questions after a pilot tested for comprehension in a group of 10 patients. These interviews were conducted individually with one pupil being interviewed by one researcher. Respondents who had acne would be examined, diagnosed by a dermatologist (Tran Thi Hanh).

Typical cases would be illustrated by photograph. Determination of acne severity (mild, moderate, severe) based on the number and type of lesions; a standardized system was outlined below:

<table>
<thead>
<tr>
<th>Severity</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>&lt; 20 comedones, or &lt; 15 inflammatory lesions, or &lt; 30 total lesions</td>
</tr>
<tr>
<td>Moderate</td>
<td>20 to 100 comedones, or 15 to 50 inflammatory lesions, or 30 to 125 total lesions</td>
</tr>
<tr>
<td>Severe</td>
<td>&gt; 5 cysts, or total comedone count &gt; 100, or total inflammatory lesion count &gt; 50, or &gt; 125 total lesions</td>
</tr>
</tbody>
</table>

**STATISTICS:**
The statistical analysis was performed using the SPSS software version 15.0 and Excel.

**MEDICAL ETHICS:**
This research is non-invasive, in compliance with the principles of human research set forth by the Helsinki declaration. Students are entitled to attend and withdraw at anytime; they are examined and treated if required

**RESULTS:**
405 cases were included, of which 143 were males and 262 females. Ages ranged from 15 years old (pupils in grade 10) (30.4%), to 16 years (pupils in grade 11) (29.9%) and 17 years (pupils in grade 12) (39.8%).

<table>
<thead>
<tr>
<th>Table 1 The prevalence of acne with respect to gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
</tr>
<tr>
<td>----------</td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Total (n=405)</td>
</tr>
</tbody>
</table>

\[X^2 = 0.32; p = 0.57 > 0.05\]
Most of acne was seen on oily skinned sufferers. The most common lesions encountered were comedones, then papules and pustules. Nodules and cystic lesions were seen in low proportion.

### Table 2: The Skin lesions of acne sufferers

<table>
<thead>
<tr>
<th>Lesions</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oily skin</td>
<td>291</td>
<td>87.1%</td>
</tr>
<tr>
<td>Comedone</td>
<td>334</td>
<td>100%</td>
</tr>
<tr>
<td>Papules</td>
<td>164</td>
<td>49.1%</td>
</tr>
<tr>
<td>Pustules</td>
<td>146</td>
<td>43.7%</td>
</tr>
<tr>
<td>Nodule</td>
<td>62</td>
<td>18.6%</td>
</tr>
<tr>
<td>Cyst</td>
<td>17</td>
<td>8.1%</td>
</tr>
<tr>
<td>Hypopigmentation</td>
<td>3</td>
<td>0.9%</td>
</tr>
<tr>
<td>Hyperpigmentation</td>
<td>136</td>
<td>40.7%</td>
</tr>
<tr>
<td>Pitted scar</td>
<td>111</td>
<td>33.2%</td>
</tr>
<tr>
<td>Hypertrophy scar</td>
<td>3</td>
<td>0.9%</td>
</tr>
<tr>
<td>Dermatrophy and telangiectasie</td>
<td>26</td>
<td>7.8%</td>
</tr>
</tbody>
</table>

### Distribution of acne lesions on the body

Acne lesions were mostly seen on the face 334 (100%), then on the back 95 (28.4%), the chest 41 (12.3%), and the arm 16 (4.8%). On the face, the most common lesions were on the cheek 308 (92.2%), the forehead 281 (84.1%), the nose 279 (83.5%), the chin 207 (62%), and the temple 113 (33.8%).

### Distribution of pupils using topical corticoid and mixed cream

(steroids, aspirin, antibiotics, self-concocted vitamins): Among 405 cases reported, 76 (18.8%) of the pupils with acne used mixed cream and steroid containing topical products.

Although no significant association was found by the Chi Square Test but the OR >1 showed that the acne subjects using corticoid had the Odd of dermatrophy and telangiectasie 2,14 times more often than the non acne users.

### Table 3: Correlation between Dermatophytelangiectasie and using Corticoid containing products (mixed cream, topical drugs)

<table>
<thead>
<tr>
<th>Using status</th>
<th>Users (n=61)</th>
<th>Non-Users (273)</th>
<th>Total (n=334)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dermatophytelangiectasie</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>n=26 (%)</td>
<td>8 (13.1)</td>
<td>53 (86.9)</td>
<td>18 (6.6)</td>
</tr>
<tr>
<td>P (Fisher’s Exact Test)</td>
<td>0.11</td>
<td></td>
<td>0.02;</td>
</tr>
</tbody>
</table>

**OR = 2.14. CI: 95% (0.88 - 5.18)**

### Figure 1: Classification of acne degree

### Table 4: Correlation between gender and the degree of acne

<table>
<thead>
<tr>
<th>Gender</th>
<th>Mild n (%)</th>
<th>Moderate n (%)</th>
<th>Severe n (%)</th>
<th>P=</th>
<th>OR=</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>46 (37.1)</td>
<td>72 (58.1)</td>
<td>6 (4.8)</td>
<td>0.02;</td>
<td>1.72</td>
</tr>
<tr>
<td>Female</td>
<td>110 (52.4)</td>
<td>100 (47.6)</td>
<td>0 (0%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>156 (46.7)</td>
<td>172 (51.5)</td>
<td>6 (1.8)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Concern of acne with respect to gender - Treatment seeking behaviours

282 (84.4%) pupils with acne are concern about their problem. Males appear to be less concern about their acne when compared to females ($\chi^2=8.6; p = 0.003$). There was an association between this concern and gender. Here there was a big difference with girls wanting to deal with the problem and treat acne through various means such as facial massage, cleaning with facial milk, and using cosmetics. Most of the times boys did nothing and left the problem untreated. Despite the high rate of pupils (84.4%) concerned with their acne there were still high rates of non - treatment (53%), self - treatment (37.4%), treatment at private clinics (6%), beauty salons (0.7%), and only 2.7% of pupils are seen in dermatology clinics.
### Table 5  The relationship between diet and acne

<table>
<thead>
<tr>
<th>Daily Diet</th>
<th>Acne (+)</th>
<th>No Acne (-)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
<td></td>
</tr>
<tr>
<td>High lipids (fat, eggs, milk)</td>
<td>194 (85.1)</td>
<td>140 (79.1)</td>
<td>34 (14.9)</td>
</tr>
<tr>
<td>High glucose (bread, cereal, cake, sugar)</td>
<td>149 (83.2)</td>
<td>185 (81.9)</td>
<td>30 (16.8)</td>
</tr>
<tr>
<td>Fruit with high sugar</td>
<td>148 (83.1)</td>
<td>186 (81.9)</td>
<td>30 (16.9)</td>
</tr>
<tr>
<td>Fruit with low sugar</td>
<td>240 (83.6)</td>
<td>94 (79.7)</td>
<td>47 (16.4)</td>
</tr>
<tr>
<td>Chocolate, cacao</td>
<td>72 (80)</td>
<td>262 (83.2)</td>
<td>18 (20)</td>
</tr>
<tr>
<td>High protide (meat, fish)</td>
<td>246 (80.4)</td>
<td>88 (88.9)</td>
<td>60 (19.6)</td>
</tr>
<tr>
<td>Vegetable</td>
<td>297 (82.7)</td>
<td>37 (80.4)</td>
<td>62 (17.3)</td>
</tr>
</tbody>
</table>

(+): Eat regularly everyday  (-): Eat irregularly

### Impact of acne

Boys with acne were more diffident (p=0.01), depressed (p=0.05), ashamed (p=0.003) than girls.

### Table 6  Association between facial hygiene, cosmetic use and acne

<table>
<thead>
<tr>
<th></th>
<th>Acne</th>
<th>No Acne</th>
<th>Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average number of facial cleaning/day</td>
<td>n=334 (4.32)</td>
<td>n=71 (4.54)</td>
<td>T test, p=0.31&gt;0.05</td>
</tr>
<tr>
<td>Cosmetic use</td>
<td>n=174 (87.9%)</td>
<td>n=24 (12.1%)</td>
<td>$\chi^2$, p=0.01&lt;0.05 OR=2.12</td>
</tr>
</tbody>
</table>

### Table 7  Association between behaviors and gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>Male</th>
<th>Female</th>
<th>Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acne squeezing</td>
<td>78 (54.5%)</td>
<td>154 (58.8%)</td>
<td>$\chi^2$, p=0.01</td>
</tr>
<tr>
<td>Facial Massage</td>
<td>9 (6.3%)</td>
<td>369 (13.7%)</td>
<td>$\chi^2$, p=0.41</td>
</tr>
<tr>
<td>Facial Milk</td>
<td>55 (38.5%)</td>
<td>163 (62.2%)</td>
<td>$\chi^2$, p=0.01</td>
</tr>
<tr>
<td>Cosmetic</td>
<td>50 (35%)</td>
<td>148 (56.5%)</td>
<td>$\chi^2$, p=0.001</td>
</tr>
</tbody>
</table>

### Impact of acne on personal friendships

Boys with acne were less communicative than girls (p=0.03).
Discussion
The research has confirmed that acne was a common health problem among adolescents from 15-17 years of age, impacting 83.9% of the males and 81.7% of the females (p = 0.57). The prevalence of acne in both sexes was 82.5%. This figure concur with the results noted by Saurat and Klaus Degit who found the rate at 80%, and Julie C Harper who showed it at 85-100%. In this study, mild and moderate acne were the most common and occurred in almost equal numbers in both genders. Moderate acne was 1.72 times more common in males than females (p = 0.02, OR = 1.72). This finding was also in line with the literature on acne among young adults which was more severe in males than in females.

Oily skin was the most common contributing factor to the onset of acne. This figure was in line with literature as over excretion of oil usually preceded the acne problem and remained as a factor as the disease progressed unless treated. Comedone was often present as it was the most observed lesion in common acne among young adults in our study. Papules, pustules were lesions of the ongoing inflammation and were observed in high proportions. Other lesions such as nodule, cyst, hypertrophy scar were common in severe acne, particular in adults, or in patients who had complications due to inappropriate treatment. These lesions had low proportions. Specifically, dermatrophy and telangiectasie was a result of an inappropriate treatment, or using steroid containing drugs or cosmetics.

Historically, the relationship between diet and acne has been highly controversial. Whitney P. Bowe have included several studies that he believes are of inferior design in an effort to provide historical context for more recent developments, and to address several dietary factors that, in his opinion, merit further study. Before the 1960s, certain foods were thought to exacerbate acne. However, subsequent studies, dispelled these alleged associations as myth for almost half a century. Several studies during the last decade have prompted dermatologists to revisit the potential link between diet and acne. Compelling evidence exists that high glycemic load diets may exacerbate acne. Adebamowo et al may have provided consistent data in support of an epidemiologically weak association between dairy and acne. Dairy ingestion appears to be weakly associated with acne, and dietary fibers remain to be elucidated. In our study, there were no association between diet and acne. Limitation included the number of the controlled group were much lower than the group with acne problem.

Research has continued to yield more information concerning the aggravating factors of acne. Recognition of the bad habits of the pupils with acne such as acne squeezing and facial massage that would risk worsening and spreading the inflammation, and making acne more serious, and more specifically the role of facial milk and cosmetics in the development of acne. There was a correlation between cosmetic use and gender with the girls using at a much higher rate than the boys. In addition, this study also found a significant correlation between this habit and acne and frequent cosmetic users who had a higher risk (2.14 times) than non users of acne problems. We should educate pupils more about the ingredients contained in facial milks and cosmetics and their connection in producing comedone.

Some research showed a strong association between acne and mental health. This study also found that acne had a psychological impact to patients themselves, to their friendships, to their relationships with families and school performance. The degree of impact is depended on gender where females were more influenced than males. This finding is also noted by Aktan et al. The most common impact was loss of confidence, ashamed, avoiding communication, avoiding social gathering, lacking of focus when studying. According to Rigopoulos et al, 48% of high school pupils in Greece said that acne harmed their personal relationships. According to Jancin B 39% of British young adults neglected schools due to their personal shame, 55% said that acne made them could not find girlfriends or boyfriends.

Conclusion
The prevalence of acne in Chau Van Liem Senior High School pupils is 82.5%. Pupils still display bad habits like acne squeezing, applying cosmetics, using mixed- cream bought from the store or self concocted mixtures of locally obtainable creams including steroids, aspirin, antibiotics, vitamins, carelessly applying corticoid-contained medicine which harm their skin. Acne also affects their
mental health, emotional well being, and performance in school, family relationships, and friendships. These conclusions from our study are very essential for our acne prevention school programs.

References

Adequacy of Care in patient with Psoriasis (ADECAP) Study

Tan WC, Chan LC, Ong KP, Tan SS, Kweh MW, Jeffrey L, Kalaikumar N

Abstract

Introduction: Psoriasis is a chronic recurrent inflammatory skin disease and poses a lifelong burden. Psoriasis is now considered a systemic inflammatory disease. Increasing epidemiological studies have established the role of psoriasis as an independent risk factor in the development of metabolic syndrome and its components. This has led to changes in standard of care recommendations for patients with psoriasis. We conducted a clinical audit on “adequacy of care in patient with psoriasis”.

Objective: To examine current trend of practice in the treatment of adults with psoriasis in Dermatology clinic (tertiary referral centre), Penang Hospital. This study also aims to determine the adequacy of care in psoriasis patients in general, and those on systemic agents in specific.

Method: A retrospective study examined all adult psoriasis patients who visited Dermatology Clinic, Penang Hospital within 1st July - 31st July 2009. Only those who have been on follow-up for at least 1 year were included in the study. Demographic characteristics, disease burden and details of psoriasis management were documented and analysed. Standards were derived from recommendations of the British Association of Dermatologists (BAD) and American Academy of Dermatology (AAD).

Results: Of the 112 patients, 67 were males (59.8%). The mean age of patients was 48.8 years. Fifty (44.6%) were Chinese, 35 Malay (31.3%), 26 Indians (23.2%) and 1 foreigner (0.9%). The mean frequency of clinic visit was 8.2. Forty-seven patients required systemic agents to achieve better disease control. Eighty-three (74.1%) patients were offered “Psoriasis Education Programme”. Percentage of patients who had their severity scoring done by using the DLQI, BSA & Pain score were 73.2%, 90.2% and 85.7% respectively. Only less than 50% of our patients were offered “Metabolic Syndrome Risk Factors Screening”. Of those on systemic agents, only 87.2% and 46.8% of patients, had their baseline and follow up blood investigations done respectively.

Conclusion: The care of psoriasis patients in Dermatology Clinic, Penang Hospital is still not adequate. Particular areas of concern include blood monitoring for those on systemic agents and screening for metabolic syndrome risk factors.

Remedial measures: Guidelines have been designed to create awareness and to educate doctors and patients on psoriasis and its association with metabolic syndrome. This includes a flow chart / tables to facilitate monitoring and screening of patients. Patients will be given pamphlets on the general knowledge on psoriasis, treatments and the risk of co-morbidities.

Keywords Psoriasis, Standard of Care, Clinical Audit, Metabolic Syndrome

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### Introduction
Psoriasis is a chronic recurrent inflammatory skin disease that affects between 1 - 3% of the population and it poses a lifelong burden. Advances in our understanding of the pathophysiology of psoriasis in the last decades have changed our insight of psoriasis and its management.

Psoriasis is now considered a systemic inflammatory disease. The scientific literature linking psoriasis to metabolic syndrome and its components, as well as atherosclerosis and myocardial infarction has rapidly expanded. Increasing epidemiological studies are establishing the directionality of these associations and the role of psoriasis as an independent risk factor in developing this outcomes.

This concept has led to changes in standard of care recommendations for patients with psoriasis. Due to increased awareness about treatments and comorbidities combined with increase expectations among patients, there is an urgent need to improve the quality of care for patients with psoriasis.

We conducted a clinical audit on “adequacy of care in patient with psoriasis” in July 2009. The primary objective is to examine current trend of practice in the treatment of adults with psoriasis in the Dermatology clinic, Penang Hospital. The secondary objective is to determine the adequacy of care in psoriatic patients in general, and those on systemic agents in specific.

### Methodology
This is a retrospective study reviewing the clinic cards of all psoriasis patients who visited the Dermatology Clinic, Penang Hospital within 1st July - 31st July 2009.

### Patient groups and sample
The subjects to be included in this clinical audit are all adult psoriatic patients who have been followed up in Dermatology Clinic for at least 1 year. The newly diagnosed psoriatic patients, or those follow up less than a year are excluded from this study.

**Inclusion Criteria**
1. Patient confirmed to have psoriasis
2. Patient of age ≥ 18 years at the time of study

**Exclusion Criteria**
1. Patient whom the diagnosis is in doubt
2. The newly diagnosed psoriatic patient or those follow up less than a year in skin clinic, Penang Hospital.

### Data sources
The audit criteria require data to be collected from a range of sources, including patient records and admission notes.

### Audit criteria and standards
Standards of good care of Psoriasis patients were derived from recommendations of the British Association of Dermatologists (BAD) and American Academy of Dermatology (AAD).

<table>
<thead>
<tr>
<th>CRITERION 1</th>
<th>Percentage of psoriasis patients being offered “Psoriasis Education Programme”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exceptions</td>
<td>None</td>
</tr>
<tr>
<td>Settings</td>
<td>All</td>
</tr>
<tr>
<td>Standard</td>
<td>100%</td>
</tr>
<tr>
<td>Definitions</td>
<td>Patients should be offered information to help them make informed decisions about their healthcare. This covers the condition, treatments and the health service providing care.</td>
</tr>
</tbody>
</table>
CRITERION 2
Percentage of patients who had their severity scoring done by using the
Dermatology Life Quality Index (DLQI)
Body Surface Area (BSA) / Psoriasis Area & Severity Index (PASI)
Pain score (if arthropathy)

Exceptions
If patients do not have arthropathy, omit pain score.

Settings
All

Standard
100%

Definitions
Patients should have their severity scoring done.
DLQI (Every 6 monthly)
BSA / PASI (Every visit)
Pain score (Every visit)

CRITERION 3
Percentage of patients offered “Metabolic Syndrome Risk Factors Screening”
Obesity (Body Mass Index - BMI / Waist circumference)
Hypertension (Blood Pressure)
Diabetes Mellitus (Fasting Blood Sugar)
Lipid (Fasting Lipid Profile)

Exceptions
Those < 20 years old and with pre-existing metabolic syndrome

Settings
All

Standard
100%

Definitions
Patients should be offered information about psoriasis co-morbidities and screen
them annually if ≥ 20 years old.

CRITERION 4
Percentage of patients (on systemic agents) had their laboratory investigations done
Baseline investigations
Follow up monitoring

Exceptions
Those on topical medications alone

Settings
All

Standard
100%

Definitions
Patients on systemic agent should be monitored according to JAAD 2008 guideline.

CRITERION 5
Percentage of patients consented prior to initiation of systemic agents

Exceptions
Those on topical medications alone

Settings
All

Standard
100%

Definitions
Patients should be offered written information to help them make informed
decisions about their healthcare. This should cover the condition, treatments and the
health service providing care. Information should be available in formats appropriate
to the individual, taking into account language, age and physical, sensory or learning
disabilities.
Re-audit
If the first data collection and analysis shows room for improvement, an action plan will be developed and the audit re-run once changes to the service have had time to make an impact.

Results
Study Cohort
Of 112 patients, 67 were males (59.8%). The mean age of patients was 48.8 years. Fifty (44.6%) were Chinese, 35 Malay (31.3%), 26 Indians (23.2%) and 1 foreigner (0.9%). The mean frequency of clinic visit was 8.2. Forty-seven patients required systemic agents to achieve better disease control.

Psoriasis Care Pattern (Refer table 1)
Eighty-three (74.1%) patients were offered “Psoriasis Education Programme”. Percentage of patients who had their severity scoring done by using the DLQI, BSA & Pain score were 73.2%, 90.2% and 85.7% respectively. Only less than 50% of our patients were offered “Metabolic Syndrome Risk Factors Screening”. The details of metabolic syndrome and its’ risk factor are shown in table 2. Of those on systemic agents, only 87.2% and 46.8% of patients, had their baseline and follow up blood investigations done respectively.

Table 1 Results of Psoriasis Care Pattern Observed

<table>
<thead>
<tr>
<th>Care Pattern</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psoriasis Education Programme</td>
<td>83</td>
<td>29</td>
</tr>
<tr>
<td>Psoriasis Severity Score</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin Examination (BSA / PASI)</td>
<td>101</td>
<td>11</td>
</tr>
<tr>
<td>Pain score (if arthropathy)</td>
<td>96</td>
<td>16</td>
</tr>
<tr>
<td>QoL Questionnaire (DLQI)</td>
<td>82</td>
<td>30</td>
</tr>
<tr>
<td>Metabolic Syndrome Risk Factors Screening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DM Screening</td>
<td>50</td>
<td>62</td>
</tr>
<tr>
<td>Hyperlipidaemia Screening</td>
<td>46</td>
<td>66</td>
</tr>
<tr>
<td>Hypertension Screening</td>
<td>27</td>
<td>85</td>
</tr>
<tr>
<td>Obesity Screening</td>
<td>86</td>
<td>26</td>
</tr>
<tr>
<td>Laboratory Monitoring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(If on systemic agents, N = 47)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline investigations</td>
<td>41</td>
<td>6</td>
</tr>
<tr>
<td>Follow up monitoring</td>
<td>22</td>
<td>25</td>
</tr>
<tr>
<td>Consent Prior to Initiation of Systemic Agents (N = 47)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methotrexate (N = 28)</td>
<td>0</td>
<td>28</td>
</tr>
<tr>
<td>Acitretin (N =19)</td>
<td>4</td>
<td>15</td>
</tr>
<tr>
<td>Cyclosporin (N =0)</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 2 Co-morbidities observed among the study cohort

<table>
<thead>
<tr>
<th>Care Pattern</th>
<th>Pre-existing</th>
<th>Newly diagnosed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Diabetes Mellitus (DM)</td>
<td>18</td>
<td>16.1</td>
</tr>
<tr>
<td>Hypertension</td>
<td>25</td>
<td>22.3</td>
</tr>
<tr>
<td>Hyperlipidaemia</td>
<td>19</td>
<td>17</td>
</tr>
<tr>
<td>Ischaemic Heart Disease</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>Cerebrovascular Disease (CVD)</td>
<td>3</td>
<td>2.7</td>
</tr>
<tr>
<td>Obesity</td>
<td>2</td>
<td>3.6</td>
</tr>
</tbody>
</table>
Discussion

Early intervention, targeted treatment, treat-to-target strategies and the use of treatment goals is a new management approach in medicine that have been increasingly employed in the management of chronic diseases, such as diabetes, hypertension and rheumatoid arthritis over the last decade[^10]. As in other chronic diseases, well-defined treatment goals will be helpful in guiding physicians in their care of patients with psoriasis, thereby obviating poor outcomes and subsequently improve quality of psoriasis care[^11].

Central to goal-oriented strategies are three principles: establish treatment goals, regularly evaluate treatment response and modify therapy in cases of insufficient response. Clinical audit on care of psoriasis is necessary to ensure the success of goal oriented strategies. With the above intentions in mind, we proceeded to do the above audit. Patient education is critical in promoting active participation of the patient towards his/her recovery. Active participation in the decision making process through a two-way exchange of information and strong physician-patient relationships is one potential solution to motivate adherence in psoriasis patients[^12-13]. Patients with better knowledge of their condition and treatment application are more able to cope with their condition and also gain better therapeutic control. Patient education can be empowered by special education class, verbal communication during consultation and also with written take-home materials. Still about a quarter of our patients have yet to receive patient’s education programme.

Topical therapies are effective in the treatment of mild to moderate disease. However patients with moderate to severe disease usually require phototherapy or systemic agents to achieve clearance[^2-3]. In general, these more aggressive therapies have proven to be highly effective but they are not without side effects. As there is no standard therapeutic approach, the benefits and risks of the therapy must be weighed carefully for each patient and the impact of the systemic treatment should be monitored[^2-4]. Proper monitoring of treatment progress and side effects remain the cornerstone for better treatment outcome. All patients on systemic therapies should have a baseline and also regular blood investigation monitoring during follow-up. Unfortunately from our audit, of those on systemic agents, only slightly more that three quarters patients and less than half of them, had their baseline and follow up blood investigations done respectively. Emphasis should be made for close blood monitoring of all the patients, especially who are on systemic therapy.

Despite advances in the management of psoriasis, the cumulative effect of the psychological, social and physical burden borne by patients with psoriasis is still considerable. Assessment of disease severity which complement measurement of disease extent and severity and impact on psychosocial functioning and quality of life should be used to assess the appropriateness of disease modifying drugs as well as response to treatment. The most widely used tool for assessing psoriasis severity is the PASI[^4] and measures of disease severity and quality of life impairment is Dermatology Life Quality Index (DLQI)^[^15-16].

Body surface area (BSA) and PASI, for the grading of psoriasis symptoms (scaling, erythema and induration/infiltration) and extent of lesions are the most commonly use parameters in clinical trials. They are useful and reliable tools for assessing psoriasis severity in patients with moderate-to-severe disease[^4]. In order to employ an independent measure of patient-reported psoriasis severity, assessment of HRQoL like DLQI was chosen as an appropriate indicator of HRQoL because of its widespread use, simplicity and reliable grading[^15-16]. The Psoriasis severity score and DLQI were assessed regularly in our patients as part of the six monthly assessments for the National Psoriasis Registry.

The concept of psoriasis is now considered a systemic inflammatory disease. Recent studies have described the association of various burdening & life threatening comorbidities with psoriasis in particularly metabolic syndrome[^4]. Metabolic syndrome has been demonstrated as a common precursor to the development of type II diabetes and cardiovascular disease as well as a risk factor for all causes mortality. Individuals with metabolic syndrome are associated with approximately 2 & 5-fold increased risk for CVD & type 2 DM respectively[^17]. These pose a serious implication on our country’s healthcare costs and services. Despite of our cohort of patients having a mean age of 48.8 years, only about half of them were screened for diabetes mellitus or hyperlipidaemia and only a quarter was screened for hypertension. We need to
do active screening for metabolic syndrome among our psoriasis patients. If they can be identified early, efforts can be undertaken to reduce their risk factors.

**Conclusion**
The care of psoriasis patients in Dermatology Clinic, Penang Hospital is not yet adequate. Doctors who treat psoriasis patients (especially more severely affected patients) need to approach the disease as a potentially multisystem disorder with regular screening and monitoring of the associated sequelae of the disease and also the complications of the treatment.

**Remedial measures**
Firstly, is to create awareness and to educate doctors and patients on psoriasis and its association with metabolic syndrome. This is done by having regular CME and psoriasis educational class. Next is to format protocol and schedule in a form of charts / tables, to facilitate monitoring and screening of patients. Patients will be given pamphlets on the general knowledge on psoriasis, treatments and the risk of co-morbidities.

Remedial measures may improve the awareness and knowledge of Psoriasis care. But it is the individual doctor’s attitude and willingness to adopt the change that makes the difference.

**References**
GENERAL DERMATOLOGY - Case Report

Syphilis - The great mimicker
Su-ming Wong¹, MRCP, Moonyza AAK², MD, Dawn A³, MRCP, Roshidah B³, FRCP

Keywords  sexually transmitted infection, plaques, Treponema

Introduction
Syphilis is an ancient sexually transmitted infection, described since centuries ago, caused by the bacterium *Treponema pallidum*. Syphilis or luetic disease is known as the great imitator as it can have myriads of clinical presentations, often making it a diagnostic challenge to clinicians. We report a patient with secondary syphilis, who presented with scaly plaques on his trunk and face, sparing the palms and soles.

Case report
Mr A is a 37-year old lorry driver who presented with a 3-month history of pruritic, well demarcated crusted plaques which started on the lateral side of his left leg. Similar smaller discrete plaques were also noted on the left thigh, trunk, back and face. He was initially treated with antihistamines and topical steroids by a general practitioner without any improvement.

Figure 1 Well demarcated scaly plaques on the back (A), left trunk (B), face (C) and legs (D). Erosions and scaly plaques on the scrotum (E).

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He is recently married, with no children. On further questioning, he admitted to having unprotected sex with multiple female partners, his most recent encounter being about a year ago. He denied intravenous drug abuse or having sex with men. He was otherwise well and had no other complaints.

On examination, there were multiple, well demarcated, discoid, hyperpigmented, scaly and thickened plaques scattered on the trunk, back, legs and face (Fig 1A-E). Lesions on the left chin and upper lip were slightly yellowish and crusted. There were also two small non-tender erosions and scattered scaly plaques on the scrotum (Fig 1F). His palms and soles were spared. There was no evidence of lymphadenopathy, hepatosplenomegaly, cardiac murmurs or neurological deficit.

Our provisional diagnosis was discoid eczema, with a differential of plaque psoriasis, hypertrophic lichen planus and secondary syphilis.

We proceeded with laboratory investigations and a skin biopsy. Serology tests for syphilis were strongly positive. His rapid plasma reagent (RPR) test was reactive at 1:128 dilution and confirmatory test with treponema pallidum haemagglutination test (TPHA) was detected. Screening for other sexually transmitted diseases including HIV, Hepatitis B, Hepatitis C, gonorrhea and Chlamydia trachomatis were negative. Skin biopsy showed typical histopathological features of syphilis including epidermal hyperplasia with parakeratosis and a dense band-like infiltrate in the upper dermis with numerous plasma cells (Fig 2). Collections of neutrophils were seen within the dermis and the epidermis especially at the stratum corneum.

A diagnosis of secondary syphilis was confirmed and he was treated with weekly intramuscular injection of benzathine penicillin 2.4 mega units for two consecutive weeks. Upon review in the clinic two weeks later, no new skin lesions were seen and the previous lesions were resolving.

Discussion

Syphilis is an ancient sexually transmitted disease caused by the bacterium *Treponema pallidum*. It has been referred to as the ‘great imitator’ of skin diseases, with a myriad of clinical manifestations, variable in appearance and presentations. It occurs worldwide and the incidence varies according to the geographical location.

In Malaysia, syphilis is one of the notifiable diseases by law. The exact extent of the problem is unknown due to underreporting, underdiagnosis and asymptomatic manifestation of the disease. It was reported that from the 1990s to 2005, there has been a decline in the number of patients seen at our local genitourinary medicine clinic (31.2% to 24.1%). However, the World Health Organization (WHO) fact sheet on AIDS and sexually transmitted infections (2004) reported that the estimated prevalence of syphilis among female sex workers has been increasing, from 16.7 between 1997-1999, to 38.2 between 2000-2001. In addition, of late, we have noted an increasing trend in sexually transmitted infections (STIs) especially of syphilis in our clinic. This could be due to the increasing practice of men having sex with men (MSM) and an increase in awareness of this disease. In China, the national surveillance program showed a re-emergence of syphilis where a total of 74,000 cases of early syphilis were diagnosed in 2005 alone, despite the eradication of syphilis in the 1960s to the 1980s.

Figure 2 (A) There is a dense lichenoid infiltrate in the superficial dermis (x4 Haematoxylin-Eosin stain) and (B) the infiltrates are mainly lymphocytes with numerous plasma cells (x40 Haematoxylin-Eosin stain).
Syphilis can be divided into several stages - primary, secondary, early latent (<1 year), late latent (>1 year) and tertiary stages. The primary stage is defined by a chancre which is typically a painless, indurated erosion or ulcer at the site of inoculation, occurring after an incubation period of between 9 to 90 days. There have been reported cases of syphilis being spread by kissing, biting or touching a person who has active lesion on the lips, oral cavity, breast or genitals. These early lesions are highly infectious and transmission is seen in approximately one third of patients exposed to these lesions.

After an incubation period ranging from 6 weeks to 6 months, lesions of secondary syphilis may appear. Clinically, secondary syphilis is often diverse, and may be subtle; the cutaneous and mucosal lesions often mimicking other skin diseases. Typical manifestations of secondary syphilis include lymphadenopathy, condylomata lata, papulosquamous eruption with palm and sole involvement, moth-eaten alopecia and snail-track mouth ulcers. Other less common cutaneous manifestations which have been described include a macular eruption (syphilitic roseolas, leukomelanoderma), papular (including psoriasiform, lichenoid, nummular syphilids), pustular, and malignant syphilids which is a nodular-ulcerative variant, has a rapid progression and frequently involves the face.

In a series of 105 patients with secondary syphilis, the dominant cutaneous manifestation was maculopapular eruption (up to 2/3 of patients), while only one patient presented with a psoriasiform-type eruption. Our patient presented with pruritic psoriasiform plaques which were discrete, sparing the palm and soles, illustrating that the disease sometime presents atypically and may be missed if not thought of.

Treatment guidelines from the World Health Organization (WHO) recommend intramuscular benzathine penicillin 2.4 megaunits either as a single dose or weekly in two to three doses is the mainstay of treatment in developing countries. Despite its clinical use for the past several decades, no resistance has been reported so far. In patients allergic to penicillin, oral doxycycline 100 mg twice daily for 2 weeks, tetracycline 500 mg four times daily for 2 weeks or azithromycin 500 mg daily for 1 week may be given. However, there have been reports of azithromycin/macrolide resistant T. pallidum in the United States and Ireland.

Conclusion
It is of great importance to be familiar with the many, varied clinical manifestations of syphilis in order to institute early appropriate treatment for quick recovery of the patient as well as to halt the spread of this curable disease. Clinicians should have a high index of suspicion in high risk patients although the clinical presentations can be protean, varying from one individual to another. Reporting is also important so that the information can be used to accurately assess the extent of this disease and to formulate policies and procedures in Malaysia, as well as being an important means of sharing information with other healthcare professionals locally and worldwide.

References
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Introduction
Primary cutaneous anaplastic large cell lymphoma (c-ALCL) is an uncommon type of cutaneous T cell lymphoma currently classified as one of the CD30+ lymphoproliferative disorders of the skin under the WHO-EORTC classification. We describe a series of three patients with c-ALCL from 2005-2009 in the Department of Dermatology, Hospital Kuala Lumpur.

Case 1
A 23-year-old clerk presented with a two-month history of two painful ulcerated plaques with purulent discharge at the right lateral thigh and inguinal region. He also had intermittent fever, loss of appetite and weight loss of 12 kg during the same period. Clinically the plaques were indurated and tender with had dusky erythematous rolled edges (Figure 1.1 & 1.2). There was ipsilateral inguinal lymphadenopathy.

The blood investigations were normal. Computed tomography (CT) scan revealed large matted right inguinal lymph nodes. Biopsy of an ulcerated plaque showed large abnormal lymphocytes with pleomorphic nuclei and prominent nucleoli but scanty cytoplasm. Mitoses was readily visible. The cells were stained positive to CD30 and epithelial membrane antigen (EMA) but negative to CD20, CD3, CD15 and anaplastic lymphoma kinase (ALK) (Figure 1.3-1.4).

Multi-agent chemotherapy consisting of cyclophosphamide, doxorubicin, vincristine and prednisolone (CHOP) was started. All lesions resolved completely following completion of four cycles of chemotherapy.

Case 2
A 60-year-old gentleman presented with multiple painful ulcerated plaques over the left foot and left leg for 10 years. There were no constitutional symptoms. Clinically, there was an indurated annular plaque studded with ulcers of various sizes at the left shin and an ulcerated plaque over the left sole. There was ipsilateral inguinal lymphadenopathy (Figure 2.1 & 2.2).

The blood investigations and CT scan of the thorax, abdomen and pelvis were normal except for left inguinal lymphadenopathy. Skin biopsies of the skin lesions demonstrated dense infiltration of large cells with pleomorphic nuclei and prominent nucleoli but scanty cytoplasm in the dermis and subcutaneous tissue. Frequent mitoses was evident. The cells were stained positive to CD3 and CD30 but negative to CD20 and ALK (Figure 2.3-2.6).

His skin lesions partially regressed with six cycles of CHOP with bleomycin. However, despite additional six cycles of cyclophosphamide, procabazine, prednisolone and methotrexate, he only achieved partial remission and experienced a relapse later. He subsequently received subcutaneous beta-interferon for a year.

During the last review, he had no new lesions, but the pre-existing lesions had not healed completely.

Keywords CD30+ lymphoproliferative disorders, cutaneous T cell lymphoma, ulcerated plaques
Figure 1.1 & 1.2 Patient 1 has ulcerated plaques at the right inguinal region and right lateral thighs with rolled edges. The hypopigmented depressed patch beside the ulcerated plaque is from a previously healed ulcer. Figure 1.3 Histology of the right inguinal ulcerated plaque showed dense dermal infiltration of large abnormal lymphocytes with pleomorphic nuclei and prominent nucleoli. Figure 1.4 The abnormal cells stained positive for CD30.

Figure 2.1 & 2.2 Patient 2 has multiple indurated annular plaques with shallow ulcers of various sizes at the left shin and left sole. Figure 2.3 & 2.4 Histology of the biopsy on the indurated plaque of left sole showed dense infiltration of large cells with prominent nuclei but scanty cytoplasm. Figure 2.5 & 2.6 The abnormal cells stained positive for CD3 and CD30.
Case 3
CJC was a 69 year-old gentleman presented with 5 month history of widespread pruritic erythematous papules, nodules and plaques over the face, neck, trunk, upper and lower limbs. He had intermittent fever with night sweats, anorexia and weight loss of 5 kg in the preceding two months.

Clinically, there were disseminated erythematous nodules and plaques on the right temporal area, neck, trunk, and extremities. There was no hepatosplenomegaly or lymphadenopathy.

Blood investigations and CT scan revealed no abnormality. Skin biopsy demonstrated dense intradermal and subcutaneous infiltration of large lymphoid cells with prominent nucleoli. Mitoses were abundant.

The cells stained positive to CD30, CD3 and EMA but negative to CD20 and ALK.

Multi-agent chemotherapy consisting of cyclophosphamide, vincristine, prednisolone and subcutaneous alemtuzumab was administered. This was followed by two cycles of cyclophosphamide, vincristine, dexamethasone, intrathecal methotrexate and subcutaneous alemtuzumab. Subsequently 3 cycles of gemcitabine, dexamethasone and cisplatin were given. His overall response to treatment was poor. Some nodules at the inguinal region became ulcerated. He died at home 7 months after diagnosis.

Discussion
Primary cutaneous anaplastic large cell lymphoma (c-ALCL) affects mainly adults with a male-to-female ratio of 1.47-3:1[1-3]. Incidentally, all three of our patients were male. The mean age of onset is 52 years. Our first patient acquired this disorder at 23 years of age. The youngest patient ever reported in the literature was a 2-year-old female[2].

The clinical presentation range from solitary or localized lesions to multifocal nodules or tumors, some of which can be ulcerated and some may regress spontaneously. The term localized refers to a few clustered lesions restricted to one anatomic area generally not exceeding 15x15cm. In our series, we described two patients who had localized nodules and plaques with only draining lymph nodes involvement, and a patient with multifocal nodules. In the first patient, the initial ulcerated plaque at his right thigh resolved transiently but subsequently recurred.

Primary c-ALCL must be distinguished from anaplastic transformation of other cutaneous lymphoma especially mycosis fungoides, and cutaneous infiltration of a systemic anaplastic large cell lymphoma (systemic ALCL). Transformed mycosis fungoides can be distinguished by the presence of patches or plaques for years. There is epidermotropism seen histologically. It carries a poorer prognosis. Systemic ALCL should be suspected if any extracutaneous disease other than regional lymph node involvement is detected. ALK+ primary systemic ALCL frequently affects younger patients and is more responsive to chemotherapy whereas ALK- primary systemic ALCL carries a poorer prognosis.

Histological examination of a lesion of cALCL typically shows a diffuse infiltrate composed of large cells with an anaplastic, pleomorphic, or immunoblastic cytomorphology and expression of the CD30 antigen by more than 75% of the tumor cells[1]. This was demonstrated in all our patients. The tumour cells were CD30+ but ALK-. A complete immunophenotyping of neoplastic cells generally show an activated CD4+ T-cell phenotype with variable loss of CD2, CD5, and/or CD3, and frequent expression of cytotoxic proteins (granzyme B, TIA-1, perforin)1,5. Some cases (less than 5%) have a CD8+ T-cell phenotype. Unlike systemic CD30+ lymphomas, most c-ALCLs express the cutaneous lymphocyte antigen (CLA), but do not express epithelial membrane antigen (EMA) and anaplastic lymphoma kinase (ALK) which indicate the 2;5 chromosomal translocation or its variants. In contrast to Hodgkin and Reed-Sternberg cells in Hodgkin disease, staining for CD15 is generally negative. Co-expression of CD56 is observed in rare cases, but does not appear to be associated with an unfavorable prognosis. The expression of differentiation and activation markers in various CD30+ lymphoproliferative diseases is shown in Table 1.
The choice of treatment in c-ALCL is based on the size, the extent, and the clinical behavior of the skin lesions. Solitary or localized nodules or plaques can be treated with radiotherapy or surgical excision. Patients with multifocal skin lesions or regional lymph node involvement may respond to systemic therapies such as methotrexate, systemic retinoids, interferon-alpha or anti-CD30 monoclonal antibody. Single or multiagent chemotherapy may be required in resistant cases. Our first and second patients who had localized plaques were treated with multiagent chemotherapy because the locations of the ulcerated plaques were not practical for complete excision or radiotherapy. Besides, there was regional lymph node involvement. Our second and third patient did not respond well to multiagent chemotherapy. Autologous bone marrow transplantation may be considered in these patients.

The prognosis of c-ALCL is reported to be good especially in solitary and localized disease. Bekkenk et al. reported excellent prognosis in 79 patients with primary c-ALCL, with 5- and 10-year disease-related survival rates exceeding 95%. In the same report, the prognosis of 11 patients who had regional lymph nodes involvement was also good, with 5- and 10-year disease-related survival rates of 91%. Our second patient survived the tumour for 14 years. The third patient who had disseminated lesions succumbed 7 months after diagnosis despite aggressive multiagent chemotherapy.

**Acknowledgement**

We would like to thank Dr Lee Bang Rom, Consultant Pathologist of Universiti Putra Malaysia for his contribution.

**References**

Cutis Verticis Gyrata Secondary to Congenital Melanocytic Naevus - A case report
Panicker VP, DNB, Dhamaramaratnam AD, DVD, Kuruvilla PJ, MD

Keywords scalp lesion, newborn, intradermal naevus

Introduction
Cutis verticis gyrata is characterised by hypertrophy and folding of skin of scalp leading to gyrated appearance. Polan and Butterworth classified it into primary and secondary forms. Secondary CVG has been described with a wide variety of causes. Congenital melanocytic naevus appears to be the most common. However it has been described with other naevoid abnormalities like Neavus lipomatoses, connective tissue nevi, genetic disorders such as neurofibromatoses, and endocrine disorders like acromegaly.

Case report
A 3 yr old boy presented with increased folding of occipital region of scalp since past 1 year. The parents reported that he had a hyperpigmented lesion in that area since birth. The developmental milestones were normal. Examination revealed 26 x 20 cm hyperpigmented plaque covering almost whole occipital region extending to temporal and parietal regions (Fig. 1). Parallel folds of skin were seen in occipital region, hair growth over the plaque was relatively normal.

Biopsy from the rugous area showed epidermis with prominent acanthosis. The upper dermis show small nodules of deeply pigmented naevus cells. The nevus cells are seen extending down into deeper dermis as single cells insinuating between collagen and also going around the follicular structures (Fig. 2). These features were suggestive of intradermal naevus. Our patient was referred to plastic surgery where he underwent wide excision and tissue expansion.

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Figure 1 Hyperpigmented plaque on the scalp
Figure 2 Histopathological examination indicating intradermal naevus
**Discussion**

Cutis verticis gyrata is hypertrophy of scalp skin with parallel or gyrate folds. Various causes of cutis verticis gyrata are: - Hereditary, traumatic, endocrinal, inflammatory, tumours and in association with other conditions. Congenital melanocytic naevus is seen in 1-2 % of newborns. The naevus cells are derived from epidermal melanocytes.

There are 3 types of congenital melanocytic nevi according to size-small, intermediate and giant. Cerebriform melanocytic naevus is a rare form of giant naevus. The naevus may present as a convoluted mass over the scalp. They have high risk for malignancy, the most common is malignant melanoma in 1.8-42% cases. In cases of cerebriform intradermal naevus, treatment is by wide surgical excision and plastic reconstruction. This case is being reported because the simultaneous occurrence of these two entities is rare.

**References**

Clinicopathogical Challenge
Dawn A¹, Lee BR², Latifah¹

Case 1
71 year-old, housewife presented with 4 months of progressive painless pruritic indurated plaques at preauricular area. There’s history of contact with black hair dye for 5 years, spectacles with metal frame, black metal hair pins. Patch test was positive to Fragrance mix, nickel, Black shampoo with irritation to organic acid cleansing foam.

1a) Tick the possible clinical differential diagnosis
- Cellulitis
- Cutaneous malignancy
- Lupus profundus
- Contact dermatitis
- Morphoea

1b) Tick the possible histopathological examination differential diagnosis
- Eosinophilic
- Cellulitis
- Angiosarcoma
- Lupus profundus
- Contact dermatitis
- Morphoea profundus

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³Department of Pathology, Hospital Kuala Lumpur
Case 2
37-year old, lorry driver with a 3 months history of scaly, well demarcated plaques on the face, trunk & legs.

2a) Tick the possible clinical differential diagnosis
- [ ] Psoriasis
- [ ] Sarcoidosis
- [ ] Cutaneous tuberculosis
- [ ] Lichen planus
- [ ] Syphilis

2b) Tick the possible histopathological examination differential diagnosis
- [ ] Lichen planus
- [ ] Cutaneous malignancy
- [ ] Psoriasis
- [ ] Sarcoidosis
- [ ] Syphilis

2c) Tick the possible provisional diagnosis
- [ ] Lichen planus
- [ ] Cutaneous malignancy
- [ ] Psoriasis
- [ ] Sarcoidosis
- [ ] Syphilis
SNIPPETS ON DERMATOLOGY DEVELOPMENT IN THE 1ST DECADE OF THE MILLENIUM

Asian Academy of Dermatology and Venereology (AADV)
Steven KW Chow

In 2002 at the 15th Regional Conference of Dermatology in Manila, the Council of the LADS met, deliberated and unanimously approved the proposal for the formation of the Asian Academy of Dermatology and Venereology.

The executive plan of the AADV calls for a structured program of dermatology CME/CPD events in Asia coordinated regionally to maximize the use of resources within the region. The primary objective of the AADV is to provide the platform to merge all major stakeholders in the field of dermatology in Asia.

In 20 November 2009 at a simple historical ceremony at Hilton Opera Hanoi the AADV was formally inaugurated with the election of a Foundation Board of the AADV consisting of:

President: Professor Unandar Budimulya (Indonesia)
Deputy Vice-Presidents: Madhuri Majumder (Malaysia) / Tranh Hau Khang (Vietnam)
Secretary-General: Steven KW Chow (Malaysia)
Honorary Treasurer: Chew Hon Nam (Malaysia)
Board members: Nopadon Nopakkun (Thailand)
Yoshiki Miyachi (Japan)
Chetan Oberai (India)
Azer Rashid (Pakistan)
Georgina Pastorfide(Philippines)
Seow Chew Swee (Singapore)
Mardziah Alias (Malaysia)
Titi Lestari (Indonesia)

Thirty five senior dermatologists were conferred with the Fellowship of the Academy (FAADV).

Correspondence
Steven KW Chow
Secretary-General
AADV
Mission Statement:
"Leadership in sharing and caring for dermatology across borders in Asia"

AADV Logo

The Charter of the AADV shall be

1. To represent and to develop the specialty of dermatology among the members of Asian national dermatological Societies/Associations

2. To enhance the status and the independent development of the various national, regional societies and associations like the LADS and the ADA

3. To act as an avenue to cater for the participation of members of other national dermatological societies currently not in either the LADS or the ADA

4. To enhance the development and sharing of best clinical practice in dermatology in Asia

5. To be the platform for the development of harmonisation of standards in dermatology amongst the Asian countries

6. To enhance cross-border social development, fellowship and technical exchange in dermatology in Asia

The Second Annual Summit of the AADV was held on 20th October 2010 in the city of Kota Kinabalu, East Malaysia. It was a meeting incorporated with the 19th Regional Conference of Dermatology (Asian-Australasian).

70 Foundation Fellows and 10 Honorary Fellows were installed.

The FAADV board was further expanded to include Vinchet Chan(Cambodia), Lai Wei (China), Prof Chrang Shi-Lin(Taipei), Professor Soyun Cho(Korea); JoAnne See (Australia).

The Board approved the development of a one year training program for dermatopathology leading to the award of a Fellowship in Dermatopathology [FAADV (Dermatopathology)] to be initiated in 2011.
It is amazing how much we have changed over the last decade. Digital technology has changed the world in profound and exciting ways. The Society has its website established by Dr Allan Yee in 2006 and was located at www.dermatology.org.my. The website gives a brief overview of our mission statement, activities and contributions to continuing medical education for the general public about the largest organ in the body - our skin.

One of the most frequently visited pages of the website was the list of dermatologists in Malaysia. We have many enquiries from the public requesting for the list of certified dermatologists in their area to consult regarding their skin problems. Among other frequently visited pages of the website are News and Events which inform members of the various CME activities in the Society, and Members Section where online medical journals are available for viewing. The archives of the Malaysian Journal of Dermatology can be accessed through the Members Section of the website. The Psoriasis Association of Malaysia also maintains a strong presence in the society website.

Access to online journals is also available to the members of the Society. The Society has subscribed to 2 journals which are Dermatologic Therapy and Dermatologic Surgery. Members can view and download the articles from these journals when they are reviewing their patient problems and when they are writing articles. The latest addition to the list of online journals available to members is Practical Reviews in Dermatology where one not only can download commentaries from review articles but can listen to the commentaries from their iPod or iPad.

One of the Society members Dr Henry Foong had established a virtual grand rounds in dermatology in 2000 which is a web based global dermatology network and gathering place for dermatologists at all levels of training to present challenging and interesting cases and to ask questions of colleagues with particular utility for those practising away from university hospitals and tertiary centres and in countries where resource materials and mentors are in short supply. Our members can use this virtual grand round to present challenging and difficult cases and get feedback from seasoned dermatologists from around the world.

References
Stephanie WH, Henry BBF, David JE

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Dermatology Training in Malaysia
Suraiya HH

Education is a continuous process and training of specialist physicians need to be dynamic and evolving all the time, responding to current needs and standards. The desired outcome of a specialist training programme in any country is to produce competent, enthused and committed specialists, capable of independent practice in their own chosen field. It would be a bonus if they also possess the potential and ability to contribute knowledge through their own research, and further enhance the discipline throughout their career.

Over the years, training programmes have evolved and sometimes even went a full circle. Taking short cuts initially, for specific good reasons. Then went on to expand to be more inclusive and thorough, injecting many prerequisites and service requirements, so that training took the long and winding road. The next phase necessarily, as training of dermatologists took too long, is to begin to streamline - to be more structured, relevant and seamless.

The challenges of any training programme have always centred on the following considerations and priorities:

- The duration of training - What is too short, what is too long, what is just right?
- How much of internal medicine training and knowledge is required for present day practicing dermatologists.
- The current number of dermatologists to serve the population of the country. Do we need to train more dermatologists and fast?
- The available expert manpower to train dermatologists locally verses the need to go overseas.
- The attraction that young doctors have towards dermatology verses competition with other medical disciplines like cardiology or neurology.
- The requirement of research during the training and overseas exposure during or after the completion of training.

Each country will weigh and give due consideration to the factors above.

The Malaysian Journey
Malaysian specialist dermatology training has changed over the years, particularly in the last decade, and is still evolving, mindful of local needs and international practices. In the 1970s, when the total number of dermatologists in the country was so few, training was short, non structured and simple, with no exit assessment. In the 1980s, in line with other disciplines of medicine, and efforts at introducing the specialist registry by the Ministry of Health and the Academy of Medicine, dermatologists need to obtain a post graduate qualification in internal medicine. This could be the MRCP(UK) or equivalent, or Masters Internal Medicine, from a Malaysian University, before they can enter a dermatology training period which was initially only one year and later increased to three years in a dermatology department. An overseas exposure in the form of a one year Diploma at St Johns Institute of Dermatology, London or other overseas centres, was often included during or after the 3 years of training. This training programme was still not ideal as it was not structured and teaching depended on local conditions at the hospitals they worked in.
By the 21st century, in early 2000, it was deemed necessary to introduce a more structured, experience based training programme, which is well supervised by qualified trainers in recognised training institutions. A post graduate internal medicine qualification is still the entry requirement. A research thesis is included in the training period. Trainees undergo an exit examination with local and external international examiners at the end of the 3 years. They are then awarded the Advanced Masters in Dermatology (UKM). Overseas training is offered to specialists after this period so that they can develop their interest in a subspecialty of dermatology of their choice. This is a pioneering collaborative effort between Ministry of Health, National University (UKM) and Dermatological Society of Malaysia (PDM) and is the current preferred method of training of dermatologists in Malaysia.

**Streamlining The Path of Training**

The quality of specialists that graduate from this system of training is excellent in that they are mature, well rounded and more than capable of independent practice any where in the world. Nevertheless, we are always mindful that it still requires a very long time to train a dermatologist in Malaysia. Therefore, as early as 2004, discussions were already being held between the professional bodies, the Ministry of Health and the Universities, on how we can train more specialists more quickly, without compromising on the outcome. Two options were considered available, possible and desirable. Both options do not alter the structured programme as developed for the Advanced Masters in Dermatology.

Option 1, is to telescope the first year of Adv M Dermatology course into the fourth(final) year of Masters in Internal Medicine course, which is the subspecialty rotation year anyway. This will shorten the total duration. Candidates that want to be dermatologists could be pre selected before entry, or they can decide to do dermatology while in the Masters Internal Medicine course.

Option 2, is to identify candidates for dermatology training at the outset. The first 2 years of training is a general internal medical rotation, with an examination in internal medicine, and then the next 3 years is full time dermatology programme as mentioned above. This would shorten the period of training even more.

Both the options are feasible without compromising the quality of dermatologists trained. Furthermore it will address most of the issues, considerations and priorities of a training programme that I mentioned in my introduction above. This ongoing evolution of training, however, requires great resolve, understanding and commitment of all responsible for the direction of specialist training in Malaysia.

**Summary**

Whatever priorities that may exist initially in a country, training programmes are usually dynamic and ever evolving processes. Continuous benchmarking with other centres globally is important so that the specialists we train are not only relevant for local needs but are able to participate in the international arena.

A seamless, structured, experience based and well supervised training programme, with a good mix of basic medical and surgical principles, strong basic dermatology and an enticing taste of dermatological subspecialties and research, with appropriate assessments during the training is ideal and achievable. A period of international/overseas exposure to broaden horizons will be invaluable.

The new young dermatologist, who will be in their early thirties, will then have ample time in their career to sub specialise further, contribute knowledge through conduct of their own research and experiences, to enhance the profession, and to teach and train others that come after them. A good training programme with dedicated mentors produce new specialists who would be better than their trainers and mentors before them. This is the aim of any training programme and it augers well for the future of the profession.
Advanced Master of Dermatology

Course Director: Head of Department of Medicine
Co-chair: National Head of Dermatology, Ministry of Health

Research Degree: Thesis required

Taught Programme: Advanced Master of Dermatology

Programme Structure: The Advanced Master of Dermatology is a full-time 3-year programme. The maximum duration allowed is 4 years.

The programme consists of 3 years sub-specialty training which is aimed at progressive mastery of knowledge, skills and attitude, increasing responsibilities and independence. The programme includes taught courses (lectures, seminars and conference), bedside dermatology procedures and clinical research thesis. The written and clinical examinations are conducted at the end of the 3-year programme.

GENERAL ENTRY REQUIREMENTS

- A Masters degree of Internal Medicine from Universiti Kebangsaan Malaysia or other universities which are recognised by the Senate; or
- Other relevant professional qualifications or related experience which are recognised as equivalent to a Masters degree by the Senate;
- Course is only offered to Malaysians
- Government of Malaysia Medical Specialist can apply 1 year after gazettement as a specialist by the Ministry of Health

Learning outcomes are measured and assessed by the trainers as follows:

1) Demonstrate advancement of knowledge, comprehension and practical skills and have the capabilities to develop or use ideas in the context of evidence based medicine

2) Apply knowledge, comprehension and practical skills to solve problems related to fields of study in new situations and multidisciplinary approach

3) Evaluate, develop new approaches and apply knowledge and practical skills in managing complex problems

4) Demonstrate leadership skills in managing the clinical team and services

5) Evaluate and make decision in clinical situations even with limited resources taking into consideration social and ethical issues

6) Communicate and present the research findings and knowledge to peers and the community related to the area of expertise
7) Develop interest and continue further training in the area of expertise for the purpose of life-long learning

8) Practice safe clinical skills and recognize own limitation

9) Formulate and conduct scientific research independently

10) Demonstrate caring attitude and sensitivities to the needs of self, patients and their families, colleagues and the community

The programme is divided into three phases:

**PHASE 1 (Year 1):** Clinical training in dermatology. This covers basic dermatology. Propose a Research Project for Approval and Conduct Research.

**PHASE 2 (Year 2):** Further training in dermatology and introduction to dermatological subspecialty areas. Continue research project.

**PHASE 3 (Year 3):** Assume responsibilities as ‘Specialist-in-training’ and complete research project and write-up as per requirements of UKM

Credit hours are not required as candidates will be based in a hospital doing full time clinical posting.

**Name of Academic Staff**

**Lecturers**
Datuk Dr Roshidah Baba, MBBS(Malaya), DipDerm(London), MRCP(UK), FRCP(London)
Datin Dr Asmah Johar, MD(UKM), MMed(UKM)
Dr Choon Siew Eng, MBBS(Malaya), MRCP(UK), FRCP(London), DipDERM(London), DipGUM(London)
Dr Pubalan Muniandy, MBBS(Malaya), MRCP(UK), DGUM(London)
Dr Rohna Ridzwan, MBBS(Malaya), MRCP(UK)
Dr Najeeb Ahmad Mohd Safdar, MBBS(U.P.), MRCP(UK), FRCP(London), DipDerm (Bangkok)
Dr Suganthi Thevarajah, MBBS(Madras), MMed(UKM)
Dr Dawn Ambrose, MD(UKM), MRCP(IRELAND)
Dr Tay Kwee Eng, MD(UKM), MRCP(UK), MMED(Singapore)
Dr Noorzalmy Azizan, MB Beh (NUI), MRCP(UK), Adv MDerma (UKM)
Dr Chang Choong Chor, MBBS(Malaya), MRCP(UK), Adv MDerma(UKM)
Dr Ng Ting Guan, MD(UKM), MRCP(UK), Adv MDerma(UKM)
Dr Chan Lee Chin, MD(USM), MMed(USM)

**Invited Lecturer**
Dr. Nopadon Noppakun, BSc in Medical Science (Bangkok), MD(Bangkok), Certificate in Dermatopathology
Continuous Professional Development - CME

36th Annual General Meeting & Malaysian Dermatology Congress

Organizers  Dermatological Society of Malaysia
Theme  Sun & Skin
Venue  Thistle Hotel, Port Dickson
Date  22 - 25 September 2011
Program website  www.dermatology.org.my

Continuous Professional Development - CME

11th Asia Pacific Environmental & Occupational Dermatology (APEODS)

Organizers  Asia Pacific Environmental & Occupational Dermatology (APEODS)
&
Contact & Occupational Dermatoses Forum of India (CODFI)

Venue  Postgraduate Institute of Medical Education & Research, Chandigarh (INDIA)
Room No. 5, 4th Floor, F - Block, Nehru Hospital
Date  14 - 16 October 2011

Deadline for abstract submission  30th June 2011
All submissions should be by e-mail to  apeods@yahoo.in
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“The 21st century pushes the use of advance technology into the forefront of clinical Medicine, however clinical skills come with experience, recognising clinical signs and symptoms. Skin rashes often look the same and confusing to the untrained eye. The author has illustrated the importance of using clinical skills in deriving to a precise diagnosis. She has linked the choice of diagnosis made by the clinician to the patient’s predicted outcome. Tips in recognising various skin conditions have been injected into this book that will assist the reader to assess themselves and improve their clinical skills. This book is recommended to medical students, front-line doctors and even specialist in fields other than Dermatology”.

Dr. Koh Chuan Keng  President of Dermatological Society of Malaysia
Obituary

ALLAN YEE KIM CHYE

Dr Allan Yee Kim Chye was Consultant Dermatologist and Director of the Hope Skin & Laser Centre at Gleneagles Medical Centre, Kuala Lumpur. He was President of the Persatuan Dermatology Malaysia from 2006 to 2008, and we remember him for his passion and commitment to the affairs of the Society, and his efforts in promoting excellence in Dermatology.

I can recall when Allan attended his first PDM meeting, looking like a well groomed doctor with his disarming smile, and unusually for a Chinese man, a striking thick moustache! He immersed himself fully in the affairs of the Society, serving in the committee, and he subsequently went on to be President of the Society. During his term as President, he worked unstintingly to institute several innovative changes, and organised some of the most exciting scientific meetings.

Dr Allan Yee was born and grew up in the small town of Seremban. He graduated with an MBBS from the University of Singapore. A fellow student fondly remembers him organizing end-of-exam expeditions to a kampong in Kuantan with his usual enthusiasm, and leading the way from Singapore in his old battered Peugeot! On returning to Malaysia, Allan worked as a medical officer and then Lecturer in Internal Medicine in the University Hospital in Kuala Lumpur. In 1988, after obtaining his MRCP, he left for the United Kingdom for postgraduate experience and worked with several prominent dermatologists including Professor William Cunliffe in Leeds and Professor John Burton in Bristol. His experience in the UK paved the way for him to invite several international authorities as guest speakers for our scientific meetings in subsequent years.

Allan returned to Malaysia in 1995 and set up private practice initially in Tung Shin Hospital, and subsequently in Gleneagles Medical Centre. In 1997 he established the Hope Skin and Laser Centre, one of the first centres in the country to offer a range of skin laser treatment for various skin diseases. Allan pioneered the establishment of The Cosmetic Dermatology and Laser Medicine Board of the Dermatological Society of Malaysia and became its first founding president. He believed that dermatologists, being experts in skin conditions should be in the forefront of carrying out and ensuring safe aesthetic procedures. He was also a Fellow of the American Society for Laser Medicine and Surgery, as well as a Fellow of the American Academy of Dermatologists and Fellow of the Royal College of Physicians. He served as the Medical Advisor to the Psoriasis Association of Federal Territory & Selangor for many years, working to organize retreats and educational events for the group.

Allan was greatly interested in research which satisfied his intellectual curiosity. He authored multiple publications and was sought after as a speaker at medical and public conferences. However, he derived the greatest satisfaction professionally when attending to his patients. His knowledge, compassion, personality and sense of humour shone through when he was with them. He believed in “going the extra mile” for those in need, and as a result, formed a special bond with his patients. Many broke down and wept upon hearing of his sudden passing, came to his funeral and paid their respects via letters, cards, and online postings.

Allan lived a principled life underpinned by a strong sense of right and wrong. He was never one to step back from a challenge if he saw something wrong. He cared enough to act and to take a stand, even if it did sometimes ruffle feathers. He was a champion of others and was a loyal friend who could be counted on and depended on always. He was ever willing to share his expertise and knowledge with his colleagues, and always remained a student of life. He valued tremendously his friends and colleagues.

Despite such a full professional life, Allan was a devoted husband and father, enjoying every spare moment of free time with his family. He took great pride and joy in teaching lessons in life and sharing experiences with his son, Jonathan, and wife Anne. Family holidays were a wonderful time of leaving stresses and demands behind and enjoying time as a close knit family. He is greatly missed by them.

Allan also held a deep commitment to God. He served actively in church and was well-respected and loved by his church brethren as he engaged in church life and sought to be of service to those in need. His deep faith guided his actions and decisions in life.

Allan will be missed because he touched so many lives positively, and he left behind an amazing legacy. He will be remembered fondly always by his friends and colleagues.

Dato Dr Sushil Kumar Ratti
“Doc, do you know that Professor Adam passed away 10 days ago?” That was the exact words that a patient told me at Skin Clinic at University Malaya Medical Centre. It came rather sudden although we know he was ill with cancer for some time, the news still came as a shock and the fact 10 days had passed before anyone in the Medical fraternity knows about it. He passed away on 31st January 2011.

Professor Adam obtained his MBBS in 1963 at the then University of Malaya in Singapore (Now National University of Singapore). He was working in the United Kingdom and was asked by the then Foundation Dean of UM, Tan Sri Professor Dr. T.J. Danaraj, to return as the first Consultant Dermatologist in University of Malaya.

Professor Adam was friend, teacher and mentor to many. Many of our current senior Consultant Dermatologists have been taught by him and his advice has been helpful early on in their careers. He has a quiet and gentle personality preferring to be humble, maintaining a low profile despite his many achievements. Chief amongst them is starting the first Immunoflourescence service in the country, whereby blood and tissue from patients with autoimmune bullous disorders were sent to the medical department at UM instead of pathology. The tissues and blood specimens would be processed by a technician under his supervision and he would report on the IMF findins and sent them out to all the skin departments in Malaysia including to Jabatan Kulit, Hospital Kuala Lumpur. This continue until 1997 when by then the pathology departments took over in providing this service.

He worked from 1968 until his retirement from government service in 1995. He then proceeded into private practice wearing three hats, working in Subang Jaya Medical Centre as a consultant Dermatologist, his own clinic in Petaling Jaya Old Town, on top of a session every Tuesdays as a visiting consultant to University Hospital from 1995 to 2007.

He was among the pioneers in the early days of Persatuan Dermatologi Malaysia and was elected the 3rd President of Persatuan Dermatologi Malaysia serving from 1978-1980. I had come to know of Professor B.A.Adam during my posting as a Lecturer in Dermatology at the Department of Medicine at University of Malaya. He was always approachable and helpful and will be missed by many who have come to know him.

Professor Adam hails from the era of early foundation professors of the Medical Faculty of University Malaya as well as PDM and his contribution to the development of Dermatology in Malaysia will be forever etch in our memory.

Dr. Koh Chuan Keng

PROFESSOR BASHER A ADAM


Answers to Clinicopathological Challenge Quiz

1a) All the above
1b) Lupus Profundus
Focal areas of basal cell vacoulation
Dense chronic infiltrates in the dermis & subcutaneous tissue
Predominantly lymphocytes & eosinophils
Lobular panniculitis.

2a) All the above
2b) Secondary syphilis
Psoriasiform hyperplasia
Lichenoid infiltrate
Plasma cells & Lymphocytes

2c) Sarcoidosis
Granulomatous infiltrates in the dermis
Epitheloid & giant cells granulomas
No necrosis
Granulomas appear naked
Asteroid body
Fite/Ziehl - Neelsen & PAS/GMS stains negative