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collective work



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Our Dermatology Online is a international journal that publishes original contributions in the field of dermatology, including papers on biochemistry, morphology and immunology of the skin.

The journal is among the few not related to dermatological associations or belonging to respective societies which guarantees complete independence. Offers a platform for review articles in areas of interest for dermatologists.

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Comments from the website: issue 1.2011 to issue 4.2011

Collective work

Our Dermatol Online. 2011; 2(Suppl. 1): 245-249

acceptance: 26.12.2011
Conflicts of interest: None

Article - issue 2.2011:

Penicillium marneffeii – AIDS defining illness

Anaparthi Usharani, M. Bharathi

N Dermatol Online. 2011; 2(2): 58-60

Comment:

Dr. Roberto Arenas (Mexico)

In this paper emphasis is made in endemic areas, but the authors are from India, and it must be mentioned because as far as I know, not many cases have been reported out of the endemic places. A better explanation of the Devi paper must be included.

Introduction: the sentence is not clear: who made the inoculation of hamsters. Also the original reference of Segretain must be included. Discussion: Itrakonazole is not well written. Another references could be interesting: Drouhet E, Dupont B: Infection a *Penicillium marneffeii*: mycose systemique a manifestations cutanées associée air SIDA. J Mycol Med 1995;5:21-34.

Article - issue 2.2011:

Enfermedad de Bowen tratada con crioterapia combinada con imiquimod topico al 5%. Tratamiento alternativo a la cirugía en pacientes mayores con comorbilidades

Lezcano Liz, Di Martino Ortiz Beatriz, Rodriguez Masi Mirtha, Knopfmacher Oilda, Bolla de Lezcano Lourdes

N Dermatol Online. 2011; 2(2): 61-64

Comment:

Dr. Roni Leonardo Teixeira (Brazil)

Job well done, succinct, but well described, even though this is a case report. I believe that alternative therapies are always welcome, especially in diseases that affect older people in any region of the skin or mucosa of the body, and variable length. Introduction: Short and consistent with historical account of Bowen's disease, its characteristics, prevalence, consistent with the literature and highlighting the importance of a treatment protocol for Bowen's disease. This work could be a first step for the authors to study the possibility of mounting such a protocol. Case report: The patient was elderly and hypertensive, with relatively large lesion in the left leg, underwent cryotherapy 5% imiquimod combined with a good outcome with minimal scarring after resolution of the case. My question is at the time of blood pressure control in patients before treatment, and would it not have more benefit from conventional surgery, with blood

pressure control? How about the cost to the patient in need of public service health, which is poor in Latin America, most of the time? Comment: The description is interesting, with support from the literature, pointing to differential diagnosis, various treatments, and finally, brilliantly, about the actual therapeutic indications described as well as costs.

Article - issue 2.2011:

Hematoma of the proximal nail fold. Report of 41 cases

Chang Patricia, Rodas Diaz Cecilia

N Dermatol Online. 2011; 2(2): 65-67

Comment:

Dr. Alin Tatu (Romania)

The article about hemangioma of the proximal nail fold is interesting. I suggest if possible some more dermoscopic pictures, maybe The Cappilaroscopy of the proximal nail fold (50X magnification) to see the state of the capillaries. Also it would be interesting if they have some dermoscopic pictures of the distal part of the nail when hematoma is on the proximal nail fold and after some weeks-months to see the eventual involvement of the nail plate. Also is interesting if some of the hematomas were organized as fibromatous hematomas or not.

Comment:

Chukwudi Nwabudike, MD Ph.D (Romania)

I think it is a good article and the information will be good for all of us to remember, i.e. trauma from oximeters. This trauma can also be a source of infection and possible gangrene if not noticed on time many patients had the trauma for more than 2 weeks!), oximeter manufacturers may take this into account in the fabrication of their equipment, to make them less traumatic. Congratulate the author on my behalf.

Comment:

Irdina Drljević, MD, Ph.D. Ass. Prof. (Bosnia and Herzegovina)

The work is original and very nice. Regards to the author and Guatemala.

Article - issue 2.2011:

The madura foot - a case report

Nazimuddin Mohammad, Chowdhury Arif, Parvin Rukhsana, Uddin Rokon, Razzak Abdur, Hoque Moydul
N Dermatol Online. 2011; 2(2): 70-73

Comment:

Dr. Roberto Arenas (Mexico)

The authors report a case with similar lesions than mycetoma and also describe the presence of granules discharging by sinus tracts. However they do not describe the color and size of these granules and they do not show these elements, they only show the Gram positive branching filaments. On the conclusion they talk about actinomycosis. As the authors properly describe actinomycetoma is caused by actinomycetes, but it is a disease than nocardiosis and than actinomycosis, the last one caused by anaerobic. It is an interesting case but diagnosis must be clarified.

Comment:

Dr. Anaparthi Usharani (India)

I have gone through the case report "Madura foot- Case report". the findings are correct. Now Madura foot is known as mycetoma foot. References mentioned are 10-15 years old. Latest references should be there.

Comment:

Dr. Alexandro Bonifaz (Mexico)

It is interesting but I think that the authors have confusion between two diseases: actinomycetoma and actinomycosis. Probably the presented case is not actinomycetoma, that is caused for aerobic actinomycetes (like Nocardia, Actinomyces and Streptomyces) and initiates later to traumatism and generally it is treated with sulphas, aminoglycosids (Amikcin and kanamycin) or amoxicillin/clavulanate and treatment has never been brought by penicillin. On the other hand the actinomycosis is a disease caused for anaerobic or microaerophilic actinomycetes (like Actinomyces) and is an endogenous infection, forms grains or granules like the mycetoma and the botriomycosis) and its treatment of choice is penicillin. Three diseases: mycetoma (actino and eumycetoma); actinomycosis and botriomycosis can be similar clinical but with different treatment.

Article - issue 2.2011:

Dermoscopy of scabies

Faruk Alendar, Irdina Drljević, Hana Helppikangas, Temeida Alendar
N Dermatol Online. 2011; 2(2): 74-75

Comment:

Dr. Alin Tatu (Romania)

As we know now Dermoscopy is a very usefull tool for diagnosing Scabies. As Geppi Argenziano said for the first time at Barcelona ISD Congress we speak now about Enthomo-Dermoscopy. As we know he was the first one to observe the Mite through the dermoscope as

in his original article published in Arch. Dermatol 1997;133;751-3. The original sign of Sarcoptes is the Brown triangle-which corresponded to the pigmented anterior area and the first pair of legs. A subtle linear segment seen below the base of the triangle was made visible by the presence of small air bubbles. Together, both structures resembled a jet with contrail. The linear segment observed on ELM was thought to be the burrow of the mite along with its eggs and fecal pellets. So the article is o.k. but is necessary to use the common defibitions like-brown triangle -for the anterior part and first pair of legs. The contrail is the burrow which contents eggs and fecal pellets. The brown triangle and the contrail -both together are named, delta wing jet sign.

Comment:

Dr. Rakesh Bharti (India)

Nicely written article—better photos and a little more detail about the technique and gadget would have made it best.

Article - issue 2.2011:

Polycystic ovarian disease: a dermatologist's viewpoint

Hassan Iffat, Keen Abid

N Dermatol Online. 2011; 2(2): 76-79

Comment:

Dr. Rukhsana Parvin (Bangladesh)

I have gone through the article: Polycystic ovarian disease: a dermatologist's viewpoint. I think it is nicely written by the authors. There are few spelling mistakes. Authors could have given some pictures which would enrich the paper. Otherwise this is fine.

Article - issue 3.2011:

Refractory onychomycosis due to Trichophyton rubrum: combination therapy with itraconazole and terbinafine

Bonifaz Alexandro, Vázquez-González Denisse, Saúl Amado, Fierro-Arias Leonel, Ponce-Olivera M. Rosa

N Dermatol Online. 2011; 3(2): 108-112

Comment:

Dr. Rukhsana Parvin (Bangladesh)

This article is nicely written. I think authors should go for more sampling of patients and try the combinations. They could show few diagram of the disease pattern and treatment response.

Comment:

Dr. Jorge Lopez-Granja (Belize)

I find this article very interesting and above all, I find that targets a problem that is very common in the daily practice: patients with onychomycosis that fail to standard treatment regimens. Congratulations to the Authors of this study.

Comment:

Irdina Drljević, MD, Ph.D. Ass. Prof. (Bosnia and Herzegovina)

The article is nice, and yes, this is an original article.

Article - issue 3.2011:

Upregulation of anti-human ribosomal protein S6-p240, topoisomerase II α , cyclin D1, Bcl-2 and anti-corneal antibodies in acute psoriasis

Abreu Velez Ana Maria, Howard William R., Howard Michael S.

N Dermatol Online. 2011; 3(2): 113-117

Comment:

Dr. Rania Mounir Abdel Hay (Egypt)

I think this is a very interested idea that needs to be further studied with larger number of patients versus uninvolved areas in the same patients to detect a significant difference.

Comment:

Irdina Drljević, MD, Ph.D. Ass. Prof. (Bosnia and Herzegovina)

In my opinion this is case report actually, and there is no need for "conclusion" as a chapter!

Article - issue 3.2011:

Reconstruction of nasal skin defects following excision of basal cell carcinoma

Al-Bdour Mohammed, Al-Khateeb Maher

N Dermatol Online. 2011; 3(2): 125-129

Comment:

Dr. Roni Leonardo Teixeira (Brazil)

I conclude that it was a job well done, interesting and instructive. I think the reasonable number of patients (N = 36), keep the care in the statistical parameters as well as proper use of the photos, preserving the identity of patients, and excellent image quality, accurately depicting the surgical approach. Another interesting fact was the author position on its complications, which nicely shows the commitment and quality of the text, despite being a retrospective study. I think the author showed a text consistent with the rules of publishing.

Article - issue 3.2011:

Tuberculosis ganglionar con afectación cutánea (escrofulodermia) en paciente inmunocompetente.

Reporte de un caso

Martinez Braga Gabriela, Di Martino Ortiz Beatriz, Rodriguez Masi Mirtha, Knopfmacher Oilda, Bolla de Lezcano Lourdes

N Dermatol Online. 2011; 3(2): 130-134

Comment:

Dr. Roberto Arenas (Mexico)

In the text it could be better to mention exophytic nodular lesions than tumoral lesions.

Article - issue 3.2011:

Gram-negative folliculitis. A rare problem or is it underdiagnosed? Case report and literature review

Sierra-Téllez Daniela, Ponce-Olivera Rosa María, Tirado-Sánchez Andrés, Hernández Marco Antonio, Bonifaz Alexandro

N Dermatol Online. 2011; 3(2): 135-138

Comment:

Dr. Anaparthi Usharani (India)

The content and photographs are good. But references are old.

Comment:

Dr. Rania Mounir Abdel Hay (Egypt)

Job well done and very well described, even though this is a case report. I believe that this is an under-diagnosed very important condition. Introduction: short and concise. Case report: very well described to the point, with support from the literature pointing to the available treatment.

Comment:

Dr. Rakesh Bharti (India)

Very well written article. Corticosteroids in pulses and or IVIG can still be tried along with, of course ,cosmetic plastic repair of the defects and anti depressants.

Article - issue 3.2011:

Pediculosis pubis

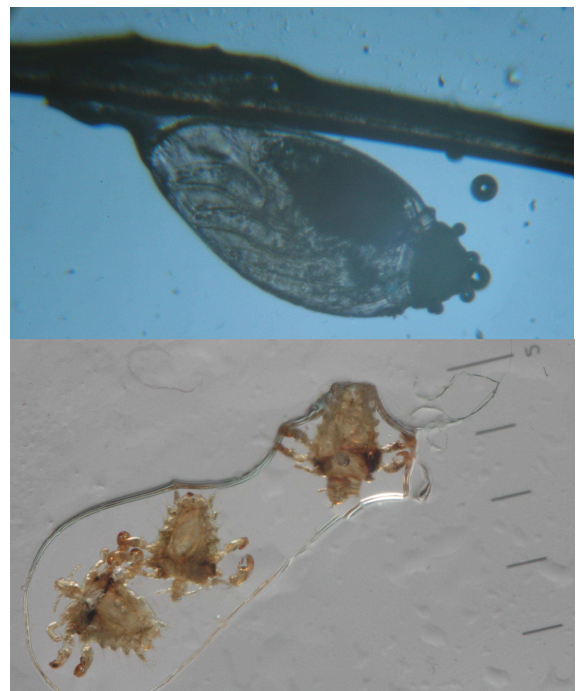
Chang Patricia

N Dermatol Online. 2011; 3(2): 156-157

Comment:

Dr. Piotr Brzezinski (Poland)

Thank you dr. Patricia Chang. I encourage everyone to microscopic diagnosis of disease.



Article - issue 4.2011:

Comparison of seropositivity of HCV between oral lichen planus and healthy control group in Hamedan province (west of Iran)

Akram Ansar, Abbas Zamanian, Mahmood Farschian, Rahim Sorouri, Ahmad Reza Mobaien

N Dermatol Online. 2011; 4(2): 181-184

Comment:

Dr. Bharti Rakesh (India)

The paper clearly busts the myth of HCV and Lichen planus relationship. The guidelines after few more such studies, should repeal HCV testing in LP patients and thus save the unnecessary testing and expenditure.

Comment:

Dr. Boaz Amichai (Israel)

Oral lichen planus is a chronic inflammatory mucocutaneous disease, whose etiology is still unknown. Immunologic disorder, dental restorative materials, stress, drugs and infectious agents have been suggested as a possible etiology factor. The correlation between HCV and OLP is still controversial. Numerous case reports and studies have been published in this issue. Part of them showed correlation between the diseases while others including the recent manuscript by Ansar et al. [1] did not found correlation between oral lichen planus and HCV.

References:

Ansar A, Zamanian A, Farschian M, Sorouri R, Mobaien AR: Comparison of seropositivity of HCV between oral lichen planus and healthy control group in Hamedan province (west of Iran). N Dermatol Online. 2011; 4: 181-184.

Comment:

Dr. Mohamed Daboul Wael (Syria)

Lichen planus is a manifestation of different diseases and it can also be present with unknown causes. In his last statement in the abstract, the author concluded " This study showed that there is no correlation between seropositivity of HCV and oral lichen planus in our patients in the west of Iran.". While his study is valuable, The author made an absolute sharp statement. Such conclusion requires further investigation. It might be more suitable to conduct an other study supporting this one, checking on Lichen planus on those patients who are HCV positive to find out the percentage of those with Lichen planus in seropositive HCV individuals.

Comment:

Dr. Anaparthi Usharani (India)

I have gone through the article " Comparison of seropositivity of HCV between oral lichen planus and healthy control group in Hamedan province of Iran" I verified various references relating to the study in literature: References:1. There is wide variation in prevalence of LP in HCV infected patients. Higher values are reported from Italy, Spain, Japan. reports from France and Germany showed low prevalence. Reports from Holland ,UK and Brazil did not show any association of HCV infection and oral LP. Ref.: IADVL

Text book of Dermatology. Third edition Vol.1 Publisher Bhalani publishing house Mumbai.pp 1074.1076. . 2.Geographical differences with regard to HCV and OralLP could related to immunogenic factors such as HLADR6 allele.....: So, I agree with the authors that there is no general correlation between HCV and oral LP. But there may be geographical variations. Ref: Text book of Dermatology Vol.2 eight edition. publishers. Wiley-Blackwell.Chapter 41:(41.2).

Article - issue 4.2011:

Rational use of fluconazole prior to attending skin & vd-opd in a tertiary Medical College Hospital in Bangladesh

Rokon Uddin, Khondaker Bulbul Sarwar, Farzana Akhter

N Dermatol Online. 2011; 4(2): 185-188

Comment:

Dr. Bharti Rakesh (India)

The paper "Rational use of Fluconazole" clearly brings out the differences between the health care set ups of developing and developed nations. The point is not rational or irrational use of various drugs, the point is how to deliver the best amongst the resources available. The message of giving short training in various specialties including dermatology ,mainly for common ailments, on regular basis to health care providers who have lesser access to latest is great.

Comment:

Dr. Katerina Hysi (Albania)

We have to be aware of irrational use of fluconazole. Because of the broad usage of fluconazole we are experiencing more often resistant cases during the treatment, where signs and symptoms of an infection persist despite adequate delivery of drug. So what do we have as result when we get fluconazole resistance? We ought to treat the patient with higher doses of fluconazole, or we ought to switch to itraconazole, or even worse we might be forced to use IV amphotericine. So why to use up a drug when we can use it rationally.

Article - issue 4.2011:

Skin cancer knowledge, attitude and behavior towards sun exposure among young adults in Lithuania

Ieva Laniauskaitė, Agnė Ožalinskaitė, Rasa Strupaitė, Matilda Bylaitė

N Dermatol Online. 2011; 4(2): 189-195

Comment:

Dr. Beatriz Di Martino Ortiz (Paraguay)

Excellent work. How many questionnaires were distributed? What is considered correct filling of the questionnaire? What kind of weather does this country have, annual average temperature in summer, winter, and so on.? I appreciate the inclusion of the questionnaire in the article, because other centers could benefit from this study and conduct future comparative studies.

Article - issue 4.2011:

Recognition of actinic keratosis. A retrospective biopsy study of the clinical diagnostic accuracy by primary care physicians compared with dermatologists. Experience in Mexico

Andrés Tirado-Sánchez, Rosa María Ponce-Olivera, Daniela Sierra-Téllez

N Dermatol Online. 2011; 4(2): 196-198

Comment:

Dr. Roberto Arenas (Mexico)

This paper show a big difference for an accuracy diagnosis of actinic keratosis between dermatologist and primary care workers (90% vs 36% $P= .001$). This results are very important because actinic keratosis are premalignant or initial malignant lesions. These means that education of primary care physician needs to be evaluated, in order to have a better prevention of skin cancer or at least to have a early diagnosis and treatment.

Comment:

Dr. Beatriz Di Martino Ortiz (Paraguay)

What were the most frequent clinical diagnoses issued in cases that did not correlate? No cases of proliferative actinic keratosis? I recommend this article in the references: Pérez C, Gómez A, Pierto A et. al. Correlación entre el diagnóstico clínico e histopatológico en el servicio de dermatología Hospital Universitario de Caracas. Estudio retrospectivo año 2000. Derm venezol 2002; 40: 48-52.

Comment:

Dr. Katerina Hysi (Albania)

As skin is exposed to the sun for long periods of time, here it comes actinic keratosis . It is not a rare disease but is often misdiagnosed. In misdiagnosis may contribute doctors, specialists, and laboratory tests. A doctor may prevent a misdiagnosis by asking a second opinion or refer the patient to a specialist. It is important because it can be the case of a skin cancer.

Comment:

Irdina Drljević, MD, Ph.D. Ass. Prof. (Bosnia and Herzegovina)

The article is an interesting. Ak IS PREACANCEROUS SKIN CONDISION, and my suggestion is to emphases that fact. What about dermoscopy investigation?! There is obvious need to mentioned that facts in this article!!!!

Article - issue 4.2011:

Seborrheic dermatitis and homeopathy

Lawrence Chukwudi Nwabudike

N Dermatol Online. 2011; 4(2): 208-210

Comment:

Dr. Alejandro Bonifaz (Mexico)

The original article: Seborrheic dermatitis (SD) and homeopathy, is interesting article, in agreement to the good clinical results of both cases treated with homeopathy. Due to the fact that SD is multifactorial disease, it would be interested to know more of its mechanism of action about this therapy and in what predisposing factor acts (sebum depot, Malassezia spp., etc). Due the author presents only two cases, would be interesting to do a study with a major number of cases, to have a more precise idea of efficiency and tolerance of the homeopathy in the SD.

Article - issue 4.2011:

Post Acne Hyperpigmentation: A Brief Review

Hari Kishan Kumar Yadalla, Sacchidanand Aradhya

N Dermatol Online. 2011; 4(2): 230-231

Comment:

Dr. Jorge Lopez-Granja (Belize)

First I would like to thank the authors for taking the time to share their view on a subject that is so common in our daily practice, at least for us that deal with type III-VI skin photo type on a regular basis. Secondly, I would like to point out that I disagree with the statement "Thus, infection of hair follicles and sebaceous glands are the real causes of hyperpigmentation". I believe that PIH in acne like in all other cases, the cause is an innate response of skin to inflammation. Of course, infection is one of the many triggers for inflammatory reaction. Also I think that the severity of PIH will not necessarily correlate with severity of acne; some patients with even mild inflammatory acne will show important PIH. Finally, I join the authors in discouraging the use of more invasive techniques to deal with PIH (lasers, dermabrasion) due to the risk of PIH to become more evident as a result of the therapeutic intervention. I believe patient education is probably the most important factor in the favorable outcome of whatever therapeutic strategy we decide to implement.