GENERAL DERMATOLOGY - Case Report

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

Tang MM, *Adv M Derm*, Chang CC, *Adv M Derm*, Affandi AM, Roshidah B, *FRCP*

Keywords *CD30+ lymphoproliferative disorders, cutaneous T cell lymphoma, ulcerated plaques*

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[1]. 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).

Correspondence
Tang Min Moon, *MRCP (UK), AdvMDerm (UKM)*
Department of Dermatology
Hospital Kuala Lumpur
Wilayah Persekutuan, Malaysia
E-mail : minmoon2005@yahoo.com

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

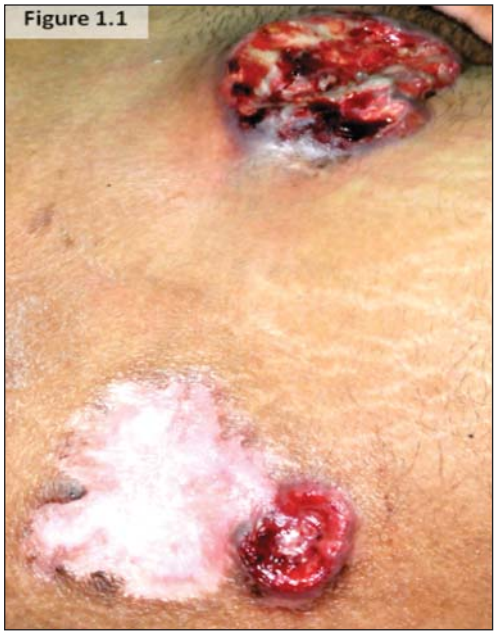
Case 2

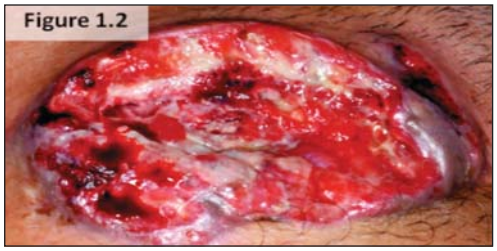
A 60-year-old gentleman presented with multiple painful ulcerated plaques over the left foot and left leg for 10 years. There were no constitutional symptoms. Clinically, there was an indurated annular plaque studded with ulcers of various sizes at the left shin and an ulcerated plaque over the left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

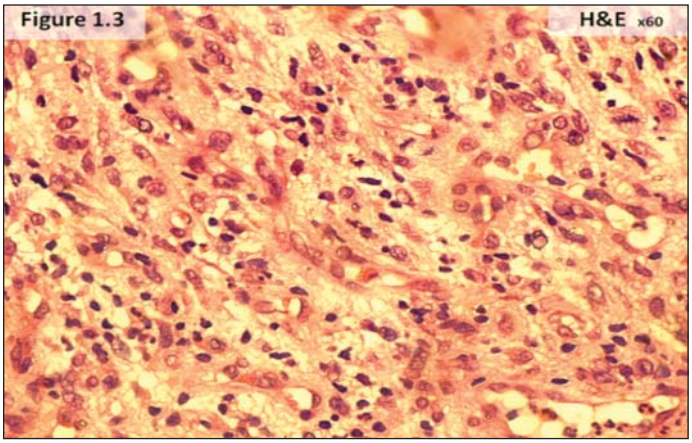
The blood investigations and CT scan of the thorax, abdomen and pelvis were normal except for left inguinal lymphadenopathy. Skin biopsies of the skin lesions demonstrated dense infiltration of large cells with pleomorphic nulcei and prominent nucleoli but scanty cytoplasm in the dermis and subcutaneous 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.







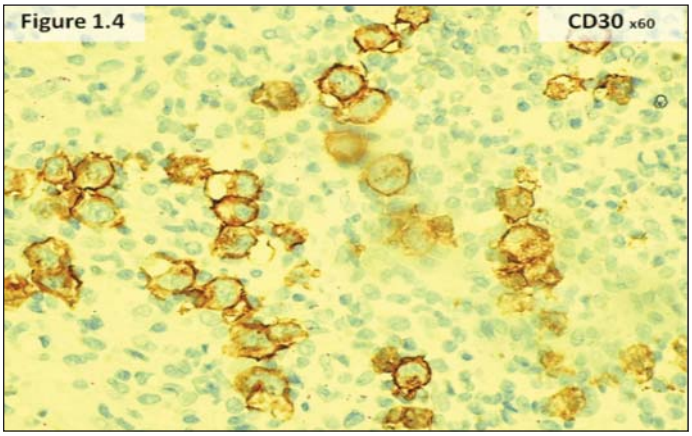
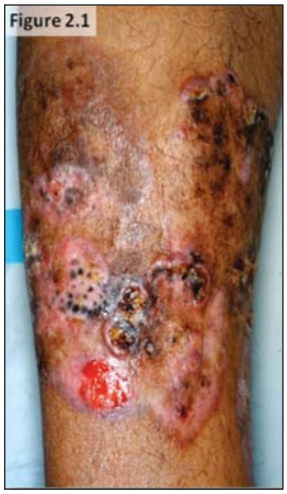
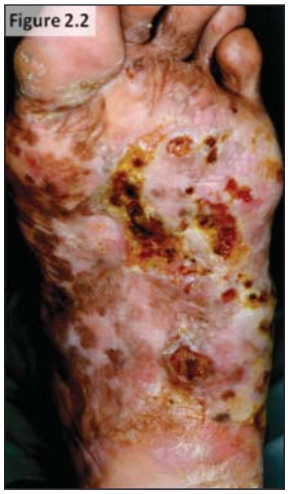
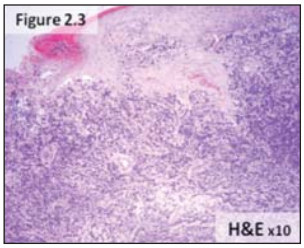
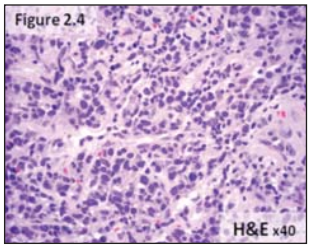


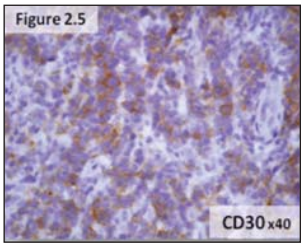
Figure 1.1 & 1.2 Patient 1 has ulcerated plaques at the right inguinal region and right lateral thighs with rolled edges. The hypopigmented depressed patch beside the ulcerated plaque is from a previously healed ulcer. **Figure 1.3** Histology of the right inguinal ulcerated plaque showed dense dermal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











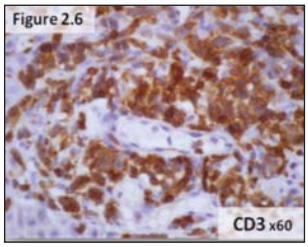


Figure 2.1 & **2.2** Patient 2 has multiple indurated annular plaques with shallow ulcers of various sizes at the left shin and left sole. **Figure 2.3** & **2.4** Histology of the biopsy on the indurated plaque of left sole showed dense infiltration of large cells with prominent nuclei but scanty cytoplasm. **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 cycloposphamide, vincristine, prednisolone and subcutaneous alemtuzumab was administered. This was followed by two cycles of cyclophosphamide, vincristine, doxorubicin, 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[3]. 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.

Table 1 Expression of differentiation and activation markers in various CD30+ lymphoproliferative diseases[5]

Disorders	CD30	CD15	CD45RO	ALK	EMA	HOXC5
Lymphomatoid papulosis	+	± (50%)	+	-	-	n.a.
Primary cutaneous ALCL	+	-	+	- (rarely +)	-	++
Ctaneous infiltration of systemic ALCL	+	±	-	+ (65%)	+	±
Hodgkin lymphoma	+	+	-	-	-	n.a.

Abbreviation: ALCL, anaplastic large cell lymphoma; ALK, anaplastic lymphoma kinase; EMA, epithelial membrane antigen; CD, cluster of differentiation; HOXC5, homeobox C5 expression; n.a., not applicable

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[1]. 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[4].

The prognosis of c-ALCL is reported to be good especially in solitary and localized disease. Bekkenk et al[3] 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

1. Willemze R, Jaffe ES, Burg G, Cerroni L, Berti E, Swerdlow SH et al. WHO-EORTC classification for cutaneous lymphomas. Blood. 2005;105:3768-85
2. Beljaards RC, Kaudewitz P, Berti E, Gianotti R, Neumann C, Rosso R et al. Primary cutaneos CD30-positive large cell lymphoma: definition of a new type of cutaneos lymphoma with favorable prognosis. A European multicenter study of 47 patients. Cancer 1993;71:2097-2104
3. Bekkenk M, Geelen FAMJ, van Voorst Vader PC, et al. Primary and secondary cutaneous CD30-positive lymphoproliferative disorders: long term follow-up data of 219 patients and guidelines for diagnosis and treatment: a report from the Dutch Cutaneous Lymphoma Group. Blood. 2000;95: 3653-3661
4. Shehan JM, Kalaaji AN, Markovic SN, Ahmed I. Management of multifocal primary cutaneous CD30+ anaplastic large cell lymphoma. J Am Acad Dermatol 2004;51:103-10
5. Burg G, Kempf W. Cutaneous Lymphoma. In Taylor & Francis Group Ed. Florida.2005: 61

GENERAL DERMATOLOGY - Short Communication

Cutis Verticis Gyrata Secondary to Congenital Melanocytic Naevus - A case report

Panicker VP, *DNB*, Dhamramaratnam 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[1] classified it into primary and secondary forms. Secondary CVG has been described with a wide variety of causes. Congenital melanocytic neavus appears to be the most common[2]. 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.

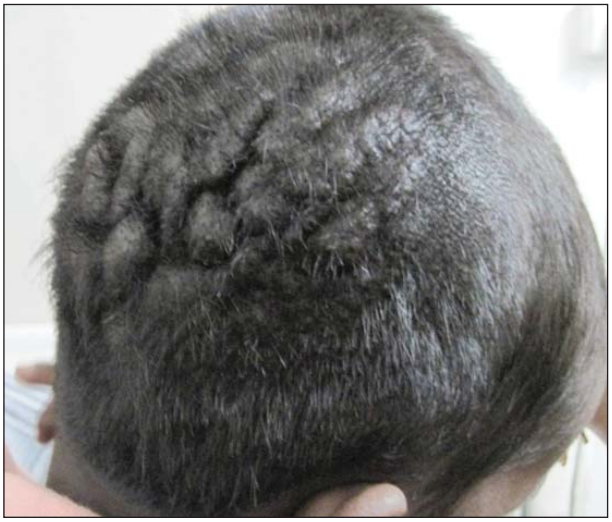


Figure 1 Hyperpigmented plaque on the scalp

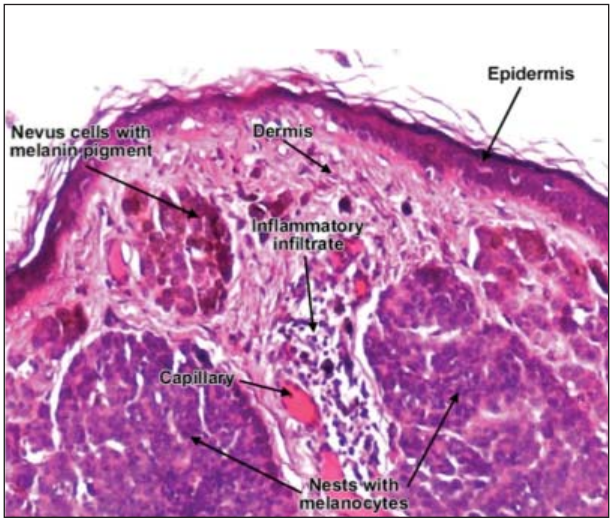


Figure 2 Histopathological examination indicating intradermal naevus

Correspondence
Vinitha Varghese Panicker, *MD, DVD, DNB*
Department of Dermatology
Amrita Institute of Medical Sciences, Cochin
E-mail : vinithavpanicker@aims.amrita.edu

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[3]. The naevus cells are derived from epidermal melanocytes[4].

There are 3 types of congenital melnocytic neavi according to size-small, intermediate and giant. Cerebriform melanocytic naevus is a rare form of giant naevus[5]. 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[6]. 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

1. Polan S, Butterworth T. Cutis verticis gyrata: a review with report of seven new cases. Am J Ment Defic 1953; 57:613-31
2. de berker DAR, Messenger AG, Sinclair RD. Disorders of hair in Burns T, Breathnach S, Cox N, Griffiths C editors Rooks textbook of Dermatology & 7th ed USA: Blackwell; 2004.p.63.68
3. Elder D, Elenitsas R. Benign pigmented lesions and malignant melanoma. In: Lever's Histopathology of Skin, 8th ed. Elder D et al editors 644-645
4. Metcalf JS, Maize JC. Melanocytic nevi and malignant melanoma. Dermatologic Clinics 1985; 3: 218
5. Pai VG, Rao GS. Congenital cerebriform melanocytic naevus with cutis verticis gyrate. Indian J Dermatol. Venereol Leprol 2002; 68 p367-8
6. Zitelli JA, Grant MG. Histologic pattern of congenital nevocytic nevi and implication for treatment. J Am Acad Dermatol 1984;11:402

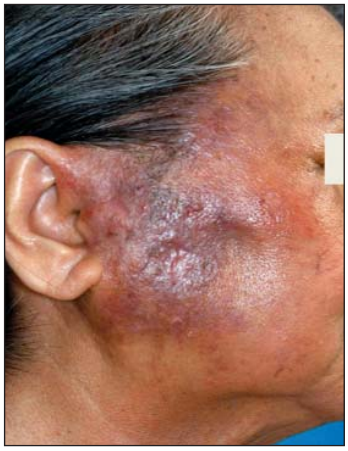
GENERAL DERMATOLOGY - Self Assessment

Clinicopatholgical Challenge

Dawn A[1], Lee BR[2], Latifah[3]

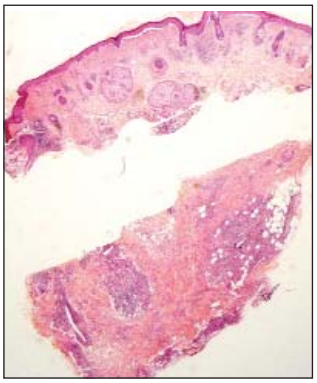
Case 1

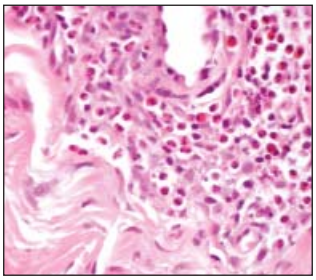
71year-old, housewife presented with 4 months of progressive painless pruritic indurated plaques at preauricular area. There's history of contact with black hair dye for 5 years, spectacles with metal frame, black metal hair pins. Patch test was positive to Fragrance mix, nickel, Black shampoo with irritation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

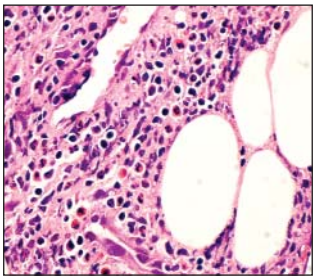


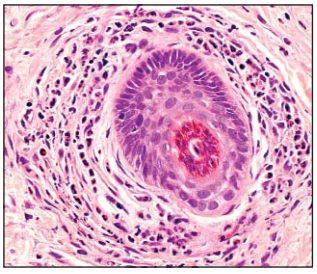
1a) Tick the possible clinical differential diagnosis

- ☐ Cellulitis
- ☐ Cutaneous malignancy
- ☐ Lupus profundus
- ☐ Contact dermatitis
- ☐ Morphoea









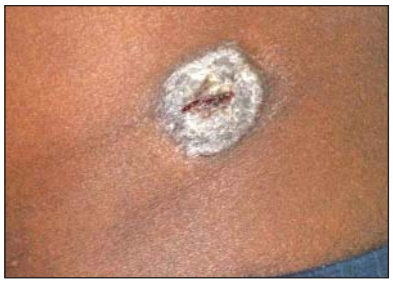
1b) Tick the possible histopathological examination differential diagnosis

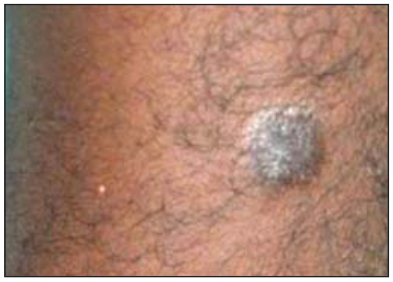
- ☐ Eosinophilic
- ☐ Cellulitis
- ☐ Angiosarcoma
- ☐ Lupus profundus
- ☐ Contact dermatitis
- ☐ Morphoea profundus

Correspondence
Dawn Ambrose
[1]Department of Dermatology, Hospital Kuala Lumpur
[2]Department of Dermatology, Universiti Putra Malaysia
[3]Department of Pathology, Hospital Kuala Lumpur

Case 2

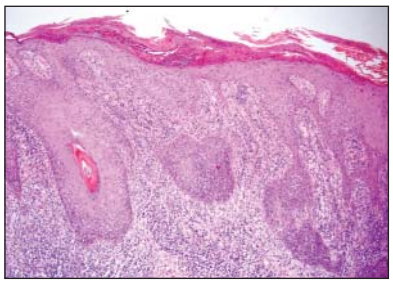
37-year old, lorry driver with a 3 months history of scaly, well demarcated plaques on the face, trunk & legs.

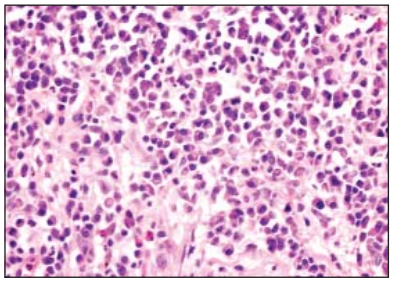




2a) Tick the possible clinical differential diagnosis

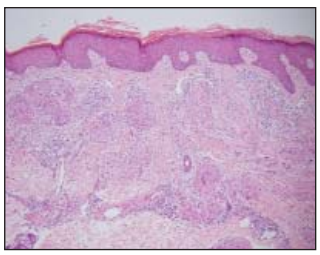
- ☐ Psoriasis
- ☐ Sarcoidosis
- ☐ Cutaneous tuberculosis
- ☐ Lichen planus
- ☐ Syphilis

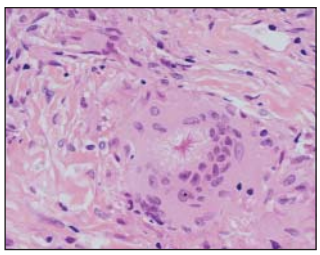




2b) Tick the possible histopathological examination differential diagnosis

- ☐ 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)

Yosihki 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

aadv
Asian Academy Of Dermatology And Venereology

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 (Dematopathology)] to be initiated in 2011.

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

Malaysian Dermatological Society's Internet Milestones

Henry FBB

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
Virtual Grand Rounds in Dermatology : an 8-year experience in web-based teledermatology. Int J Dermatol 2009:48; 1313-1319

Correspondence
Henry Foong *MBBS FRCP Edin*
Universiti Kuala Lumpur
Royal College of Medicine Perak
E-mail : bbfoong@gmail.com

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

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.

Correspondence
Suraiya H Hussein, *FRCP*
Former Head of Dermatology,
Ministry of Health, Malaysia
Senior Consultant Dermatologist
Damansara Specialist Hospital, Kuala Lumpur, Malaysia

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.

CONTINUOUS PROFESSIONAL DEVELOPMENT - Post Graduate Studies

• Faculty of Medicine

UKM website: http://pkukweb.ukm.my

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 Bch (NUI), MRCP(UK), Adv MDerm (UKM)

Dr Chang Choong Chor, MBBS(Malaya), MRCP(UK), Adv MDerm(UKM)

Dr Ng Ting Guan, MD(UKM), MRCP(UK), Adv MDerm(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

Continuous Professional Development - CME

e-Posters Presented at 22nd World Congress of Dermatology

1. Mucocutaneous manifestations of Dengue fever among patients in Universiti Kebangsaan Malaysia Medical Centre (UKMMC) - *Norazirah Md Nor, Mazlin Mohd Baseri, Sharifah Ismail, Saadiah Sulaiman, Malcolm Greaves (BRONZE AWARD)*
2. Acne myths: Personal experiences of acne patients in Malaysia - *Kun Sen Chen*
3. Lipid lowering drugs induced adverse drug reactions - *Chew Kek Lee, Yin Yin Lee, Roshidah Baba*
4. Pattern of ADR seen in Tertiary Hospital, Johor, Malaysia between 2001 - 2010 - *Malani Terpiti, Siew Eng Choon*
5. Primary Dapsone resistant Mycobacterium Leprae Infection in Malaysia; A ten year study - *Norazirah Md Nor, Adawiyah J, Mazlin MB Amrish SO*
6. Clinical skill test kit as a tool to assess housemen ability to recognise skin conditions - *Raoul Roger Sibert, Rohna Ridzwan*
7. Dilemma in managing skin nodules with sporothricoid spread - *Hazfaneza Ab Halim, Rohna Ridzwan*
8. Relationship between skin colour and minimal erythema dose to ultraviolet B radiation in multi-ethnic Malaysian population - *Yin Yin Lee, Choong Chor Chang, Asmah Johar, Suraiya Hani Hussein*
9. Assessment of skin phototype, skin colour and minimal erythema dose to ultraviolet B radiation in the multi-ethnic Malaysian Population - *Yin Yin Lee, Choong Chor Chang, Asmah Johar, Suraiya Hani Hussein*
10. Quality of life among adult patients with psoriasis: a study using data from the Malaysian Psoriasis registry - *Choong Chor Chang, Felix Boon-bin Yap, Hemandas Belani Gangaram, Roshidah Baba*
11. Safety and efficacy of ustekinumab in the treatment of Malaysians with moderate-to severe psoriasis including erythrodermic psoriasis and patients with past history of pustular flares - *Siew Eng Choon*
12. Secondary syphilis infection among patients attending genitor-urinary medicine clinic (GUM), Hospital Kuala Lumpur (2005-2009) - *Yew Thong Chong, Su-ming Wong, Jyh Jong Tang, Felix Boon-bin Yap, Choong Chor Chang, Asmah Johar, Roshidah Baba*
13. Teledermatology: providing dermatological consultation to remote hospital-based primary care clinics in Malaysia - *Choong Chor Chang, Min Moon Tang, Asmah Johar, Roshidah Baba*

Continuous Professional Development - Book Review

Doc, Patients' Outcome is in your Hands. Improve your Clinical Skill with Dermatology Clinical Skill Test Kit

Author Rohna Ridzwan **Email** rohnaridzwan@yahoo.com
Publisher Self
Year of Publication 2011 **ISBN** 978-967-10420-0-7
Available at Koperasi Kedaibuku Universiti Malaya Bhd, University Malaya Medical Centre
Price RM 80 only

"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

PROFESSOR BASHER A ADAM

"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.

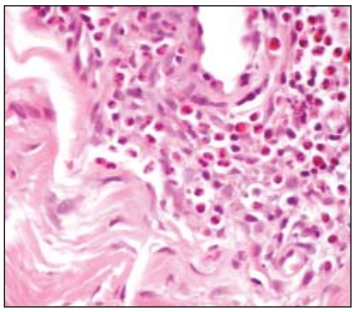
He worked from 1968 until his retirement from government service in 1995. He then proceeded into private practice wearing three hats, working in Subang Jaya Medical Centre as a consultant Dermatologist, his own clinic in Petaling Jaya Old Town, on top of a session every Tuesdays as a visiting consultant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

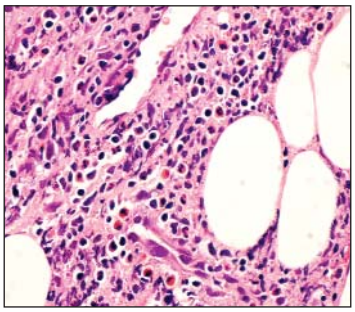
He was among the pioneers in the early days of Persatuan Dermatologi Malaysia and was elected the 3rd President of Persatuan Dermatologi Malaysia serving from 1978-1980. I had come to know of Professor B.A.Adam during my posting as a Lecturer in Dermatology at the Department of Medicine at University 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

Answers to Clinicopathological Challenge Quiz





1a) All the above

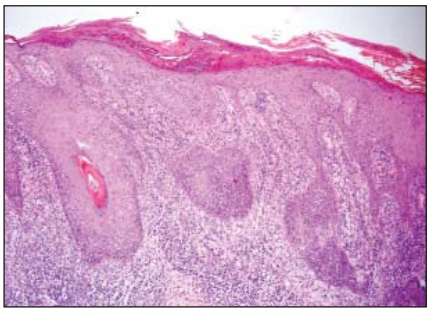
1b) Lupus Profundus

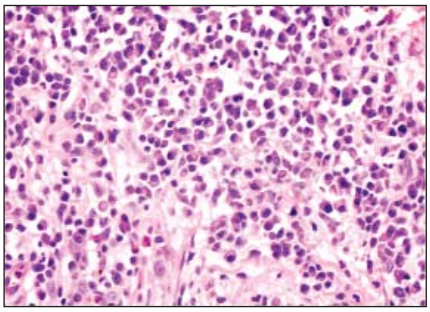
Focal areas of basal cell vacoulation

Dense chronic infiltrates in the dermis & subcutaneous tissue

Predominantly lymphocytes & eosinophils

Lobular panniculitis.





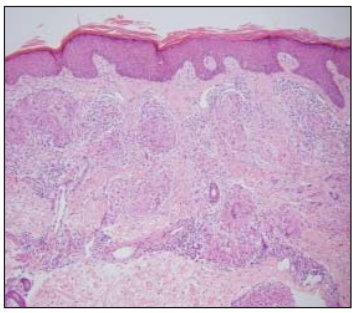
2a) All the above

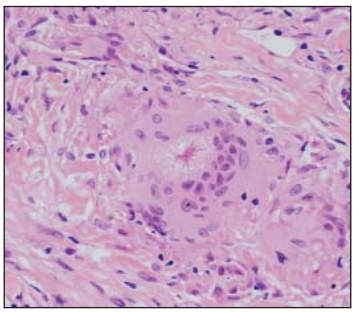
2b) Secondary syphilis

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