CHANGING TRENDS IN DERMATOLOGY

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Leprosy today is the most important skin disease from the public health point of view. With the increasing incidence of leprosy the number of leprosy patients attending the dermatology clinics is also increasing.

Probably the earliest dermatologists were physicians who took up the responsibility of looking after lepers and others suffering from chronic skin diseases in the asylums. In India the first Leprosy colony was started about a hundred years ago in 1873 by Mission to Lepers now called American Leprosy Mission Inc.

In 1890 the Acworth Leprosy Asylum was started in Bombay by collecting voluntary donations. Initially a provision was made for 250 inmates and fifty were admitted. Rajkumari Leper Asylum was started in Bengal in 1892 and in 1893 Lucknow Leprosy Hospital was started and is now associated with the Lucknow Medical College. In 1923 Belra-British Empire Leprosy relief association started its work in India.

In 1951 the Gandhi Memorial Leprosy Foundation came into existence as the Leprosy wing of Gandhi Smarak Nidhi (Gandhi National Memorial Trust). In the year 1962 it was registered as an autonomous Institution under the Societies Registration Act.

Leprosy work in India - especially looking after the maimed and deformed patients of leprosy is mainly carried out by the devoted and zealous missionaries. The first Leprosy Asylums were started by the Missionaries and even today, twenty seven years after independence their contribution towards leprosy work is outstanding. No words are enough to eulogise the selfless and devoted missionaries many of whom came to this country when they were quite young and stayed on and made this their life's work.

Though leprosy is an infectious disease its course differed from other diseases. It maimed but did not kill. Till the introduction of Sulphones in 1943 there was no satisfactory treatment for this disease. The unfortunate sufferers were ostracized from society and left on the roads or kept in an asylum, till death delivered them from the torture. The disease ran a natural course and probably burnt itself out after a few years leaving deformed human beings. It was to this unfortunate lot that the missionaries brought hope and comfort and no amount of praise is enough for their selfless work.

During this period most of the skin departments even in teaching hospitals

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did not treat leprosy probably because there was no treatment and only an asylum was necessary for the patient. The only treatment offered was Chaulmoogra oil locally or by mouth or by injection.

It was after the introduction of Sulphones in the form of Promin Injections that some ray of hope appeared for the unfortunate suffereres of this disease which brought much misery to its victims.

The social ostracism practised towards leprosy victims is criticised today; but one must consider whether in an era when there was no treatment for leprosy the only satisfactory method of prevention of the spread of the disease viz., isolation of the patient in an asylum or a home was not in the best interests of society. Now the pendulum has swung in the opposite direction. Today throughout the world the forced isolation of leprosy patients is decreasing. Unless the patients require hospitalisation for complications or deformities, treatment is usually carried out in stationary or travelling out-patient clinics. Whether voluntary isolation of lepromatous cases and cases of deformities in various asylums should be continued or the inmates discharged and asked to go away without any provision for their sustenance outside is a point which deserves serious consideration.

Objective scientific observations during the last few decades have revealed that leprosy could be highly infectious to susceptible individuals. The old ideas that leprosy is a disease of low infectivity, that it needs prolonged contact to catch the disease, that the contact should be direct and intimate are not supported by facts. Today one sees any number of new cases where there is no history of contact in the family.

India is an endemic area for leprosy and some authorities put down the incidence to be as much as 1% of the population. As the lesions first appear on the skin leprosy has become an important sub-speciality of dermatology. At the various skin clinics - especially at teaching hospitals new cases of leprosy are detected in patients seeking treatment for their skin ailment. The lesions very often are not generalized - but single or few lesions resembling some of the common skin conditions. Unless leprosy is suspected it is quite possible to miss early leprosy and label it as Tinea Versicolor, Vitiligo, Psoriasis etc. Actually just like syphilis in olden days leprosy has become the great imitator of skin diseases.

After the advent of Sulphone therapy the clinical picture of Leprosy has changed. The disease though it has increased in numbers is not as virulent as before. Hideous deformities and Leonine facies are not commonly seen. Is this due to the exhibition of Dapsone to the patients; or is the disease becoming more benign like syphilis which was very virulent during the last century? It is advisable now to distinguish between cases of leprosy which are generalised and bacteriologically positive; and those were one or a few lesions have been produced by the Lepra bacilli. The latter category even if bacteriologically positive should be allowed to continue work provided that he takes regular treatment.

Regarding the generalized advanced cases of Leprosy driven away from their village either by social ostracism or bitter poverty - and who are found on the pavements of cities - big or small, some scientific approach has to be considered. Is it enough to say to an unemployed leper that it is not necessary to isolate leprosy patients and he cannot be admitted in an institution? Is it cheaper to treat him in an institution

or allow him to remain on the roads probably infecting the susceptible individuals? It is often argued that Leprosy sufferers prefer to beg on the streets rather than remain in an institution. Is this true? or is it that the curtailment of liberty and facilities given in the institution are such that streets appear more attractive to these poor unfortunate people?

The diagnosis of Leprosy today offers a challenge not only to Dermatologists but even to neurologists, general physicians, orthopedic surgeons etc. After a case is clinically diagnosed, laboratory support is not always forthcoming in early cases. A negative smear does not rule out leprosy. In the absence of a sure test for the detection of all cases of leprosy a lot of leprosy patients go undetected.

Treatment in Leprosy has made rapid advances but it is still highly unsatisfactory and one cannot say with certainty that a leprosy patient will be cured even after 5 or more years though one can certainly expect arrest of the disease.

Due importance should be given to improving the general health of the patient. This is quite often not done especially in the poorer classes. Exhibition of Dapsone is not the be-all and end-all of the treatment of Leprosy. How many patients tolerate the drug well and how many go into reactions? The management of a case of Leprosy requires the same care and skill that one may show in treating other diseases like tuberculosis. All these aspects of leprosy will have to be studied and put on a scientific basis by the dermatologist.

In the past, many renowned foreign physicians like Cochrane, Lowe, Wade, Rogers and Muir took a keen interest in the leprosy problem of our country. Dr. Cochrane stimulated Dr. Khanolkar to undertake studies in pathology of Leprosy and he has made a notable contribution to the subject. Other workers like Dharmendra, Chatterjee, Mukherjee, and Figuerado have done research work in this field. But much more remains to be done. It will be but in the fitness of things if the dermatologists of India took up the challenge and helped in understanding the many ill-understood facets of leprosy and also in controlling the disease. A study of the various immunobiological processes, a search for tests for the diagnosis of leprosy, and a search for newer and better drugs offer interesting fields for research.

Venereology

Venereal diseases assumed special importance after the first world war. The high incidence of Syphilis and gonorrhea, in the general population and the armed forces galvanized the Government into action and special venereal diseases departments were created in teaching and other hospitals in U.K. and other centres in British Empire. In those days treatment of Syphilis was with Arsenic and Bismuth injections and the minimum period of treatment recommended was two years. Even after two years of treatment one was not certain about a biological cure.

Venereal diseases included six diseases, i.e.,

Syphilis
Gonorrhea
Chancroid
Lymphogranuloma Venereum
Granuloma Venereum or Donovanosis
Phagedena

A special Royal Commission came to India and reported about the lack of facilities for treatment and teaching of Venereal Diseases. After this, Venereal Disease Departments were set up in teaching hospitals.

The speciality of Venereal Diseases was considered a Surgical Speciality and even such operations as urethrotomy were carried out in some of the VD Departments in India. The treatment of Venereal Diseases was revolutionized after the discovery of Penicillin and the two major venereal diseases,viz Syphilis and gonorrhea showed a sharp decline in their incidence. Pencillin became available in India after the end of the second world war in 1945, and its remarkable therapeutic effect on syphilis and gonorrhea raised high hopes about our being able to eradicate these two diseases. Unfortunately the hope was not realized and the incidence of these diseases started going up and by the year 1955 showed a slight upward trend after the sharp decline during the previous decade.

In the field of diagnosis remarkable advances have been made. Newer, better and more specific serological tests have been discovered; and the Wasserman and Kahn Reactions have been replaced by the VDRL Test which is carried out in institutions all over India. Facilities for carrying out more specific tests like TPIA, RPCF, FTA etc. exist only at a few centres, the main one being the Institute of Venereology at Madras.

Culture of the gonococcus for diagonsis has also become more common for diagnosis in institutions where facilities exist.

The importance of social aspects of venereal diseases is being recognized and social workers are appointed for this work in a few centres.

The changing attitudes of Society towards sex have contributed greatly towards the increasing incidence of Venereal Diseases during recent years. The newer ideas from the West are having its effect on the youth of this country, especially in the cities.

Whether the social and moral restrictions prohibiting extramarital sex relations were necessary and more likely to develop a mature sex relationship between the husband and the wife, or the indulgence in clandestine sex contacts, freely and without inhibitions are good for the development of a better human being are questions which will be decided in course of time. But, one thing is certain, these time - honoured values of life should not be given up without a balanced consideration of all aspects of the question.

The treatment of venereal diseases has become simpler. Injections or oral medications usually suffice to cure majority of what are now known as sexually transmitted diseases.

Dermatology

Dermatology, the Science of the skin was one of the many specialities which evolved from general internal medicine during the course of the nineteenth century. Most diseases of the skin as external diseases, had for many centuries fallen within the province of the surgeons. Until the eighteenth century was well advanced, physicians with few exceptions were little concerned with the skin. The solid contributions of some such as Haberden and Cullen laid the foundations on which the pioneer specialist dermatologists of the following century were able to build.

During the last century dermatology was practised by masters like Hebra, Jadassohn, Wilson, Brocq, Unna and others. They produced beautiful pictures of various dermatological conditions and in that era quite a few diseases were named after dermatologists who described them. There were famous schools of dermatology in Britain, France and Vienna. The treatment in those days was mainly by external applications– various formulations confusing to many

of us today were used and gave remarkable results in the hands of those who had mastered the art of Dermatologic therapy.

Internally arsenic and mercury were administered for most of the chronic dermatoses--with what specific benefit or otherwise it is hard to tell. Syphilology with its multitude of skin lesions formed part of Dermatology. Nomenclature of the diseases consisted mostly of Latin words and sounded quite pompous and imposing. The prescription was so confusing to the outsider that people said a dermatological prescription consists of a drachm of Latin mixed with an ounce of Greek.

Results of therapy were so uncertain that probably the famous joke about Dermatologists - that you become a dermatologist because your patients do not get cured, they do not die and you do not get night calls was true in that era.

For a century concerned almost exclusively with the clinical description, identification and empirical treatment of diseases of the skin, dermatology was slow to develop along scienitfic lines, largely because the congested conditions of work in most clinics imposed this time saving superficial morphological approach.

During the last four decades that character of dermatology has changed and the work of the dermatologist now embraces every aspect of the biology of the skin, normal and abnormal. His present task is to integrate the accumulated wisdom of his clinical forefathers with the explosively expanding knowledge of fundamental biological processes as they involve the skin.

The system of named disease entities on which all Western medical practice is founded is an artificial concept. The frontiers of each disease are constantly shifting and a true understanding of their present significance is impossible without knowledge of their historical development. The literature on the history of Dermatology is large but much of it is anecdotal and unreliable and biased by national pride. The layman or the neophyte in medicine is likely to be astonished at the rapidity with which the experienced specialist will sometimes pronounce a dermatologic diagnosis, often in a mere instant, often after what seems but a fleeting, casual glance at the patient's skin. Contrariwise, the inexperienced person is sometimes fully as astonished by the fact that a sure diagnosis of a skin disease cannot be established or a cure delivered even after lengthy, tedious and exhaustive investigations. However, given but a little thought, neither of these happenings should awaken mistrust of the dermatologist or disrespect of the speciality.

Just like diseases of any other organ, skin diseases will, of course, sometimes require lengthy examinations by every method known to modern medicine; and of course they will sometimes even then be impossible to diagnose or cure. That this must be so becomes fully comprehensible when one considers the many different tissues and structures of the living human skin and their innumerable biologic functions as well as the great diversity of potentially pathogenic agencies to which the human skin is exposed including both those continually originating from within and those incessantly attacking from without. The skin is not only one of the largest and most complex of all organs, but the one whose diseases may result from the most varied assortment of causes.

On the other hand and returning to the first point, the seeming miracle of the experienced dermatologists lightning-like diagnosis at a glance becomes quite comprehensible when one realized that he has been conditioned by many years of study and experience to recognize

certain colours, hues, tones, configurations distributions and arrangement of lesions as characteristic of certain diseases, as the emblems of particular pathogenic mechanism. In addition to this fundamental education and experience, some skin specialists may have an exceptional endowment or gift, a flair, for recognizing the multitude of different cutaneous pictures with a special speed and certainty.

It is true that the mere recognition of clinical pictures is only the beginning and by no means the consummation of the art and science of the dermatologist But it is equally true that upon their ability to recognize and classify the clinical cutaneous pictures, depends every further important step in cutaneous medicine. Just as the recognition of letters of the alphabet is the first essential to the writer the recognition of notes to the musicians or of the colours to the painter, recognition of the clinical cutaneous changes is the first essential to the study and management of skin diseases. Without this there can be no logical or economical selection of the required further examinations; no appropriate application or evaluation of therapeutic measures, no sensible study, no scientific research upon any homogenous series of cases; no effective teaching, no clear communication of findings from individual to individual, school to school or country to country.

Dermatology was one of the first subspecialities of Internal Medicine. Many new specialities have come into being since then such as Neurology, Cardiology. Endocrinology, Gastroenterology, Nephrology, etc. Inspite of being the first, Dermatology has not received due recognition in Medical Colleges and in undergraduate teaching programmes. The time alloted for the teaching of dermatology is inadequate to inculcate in the minds of the young physicians the minimum principles of diagnosis and treatment of skin diseases. This being so the treatment given by general practitioners to skin patients who form about 15% of this practice is far from satisfactory. A young physician will know all about myocardial infarction but very little about scabies.

There is an old Irish saying, "Oh, God, give us the gift to see ourselves as others see us."

Today majority of our colleagues in the medical profession believe that we are specialists who parade big names and syndromes and do very little in the form of relief to the patients. People who matter in the field of medical education also believe that the time alloted to Dermatology and Venereology in Medical Curriculum is more than adequate. It is high time that we projected our image as a scientific speciality and convinced them of the need for adequate training in Dermatology especially because it will help the young physician, to diagnose and treat diseases which constitute about fifteen percent of his practice.

Today the Dermatologist is called upon to exhibit the skill of a good diagnostician, a good histopathologist, a good mycologist, a physiotherapist, a research woker, and also to possess surgical ability to deal with minor skin blemishes in our country and skin cancer abroad.

Let me end by praying that the Almighty may give us the ability to fulfil all these functions efficiently and to the satisfaction of the patient, who after all is our Master.