EDITORIAL

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PRESENT DAY SPECIALITY OF DERMATOLOGY ON INDIAN SCENE

Dermatology as a recognised speciality has had a chequered history to come to its present stage of recognition in the medical world. The evolution of specialities in medical science become imperative with increasing vistas of knowledge by passage of time, and in the realisation that for an individual to know everything effectively no longer remained possible. Early enough specialisation was in broader fields of those mostly curing the patient by administering medicines and others who in addition used the knife to operate on a diseased part or organ i. e., the physician and the surgeon.

The urge and need to devote one's self more intensively in a particular field became necessary and a compartmentalisation process started with one speciality ofter the other evolving as per such need, and availability of facility. Some of the specialities came in by attention to particular age group of patients e. g., paediatrics and geriatrices. Others by studies of particular diseases e. g. tuberculosis, leprosy, venereal diseases, rheumatology, allergology, etc. Some others developed by allocating study and practice of certain bodily systems such as cardiology, neurology, gastroenterology, ophthalmology, ENT, etc.

Be it as it may, the start of specialisation began and came into vogue by such process of convenience and need. Dermology started by having an indifferent course and being practised earlier by domestic and traditional methods or by quacks and barbers, who made their own recipes to apply on the easily accessible tissue organ, the skin that was affected. For unexplainable reasons the physicians, pathologists and physiologists hardly considered the cutaneous system and diverse variety of its diseases worthy of interest. The result was a neglected approach by remarks both by profession and layman that skin diseases are neither fatal nor emergent, they are hardly cured and once a patient always a patient. This seemed like giving the dog a bad name and hanging it, without appreciating the sordid morbidity the skin patient goes through with all the physical and mental discomfort. Skin diseases had been known to ancient literature with mention of diseases like leprosy, syphilis, psoriasis, leucoderma (quoted as white leprosy), etc. The earlier thought attributed skin diseases to some unspecified impurity of blood, air or water pollution, environmental factors and diet. Some of such diseases were known to be heredo-familial. The treatment, therefore, had been a change of environment and food habits, spa treatment, sea and sun bathing, etc., Internally administration of arsenic, antimony, gold, bismuth and bitters like chiraita, neem and rus along with supposed blood purifiers like sulphur bitters and sarsaprilla formed the sheet anchor of treatment.

This was followed by an era with discovery of microbes and their role in human disease which rightly lead to attribute and search for most of the skin diseases to infection by bacteria and later by fungi and viruses. There was hardly any satisfactory treatment of these infections and the patient was put on some local remedies like ammoniated mercury cream or percholor of mercury lotion, ichthyol and sulphur. The stress also came to be laid on the use of vaccines made against pyogenic cocci. In thirties came the discovery of sulphanilamide and other sulphonamides like 'prontocil' and preparations like sulphapyridin (MB693), sulphathiazol, sulphadiazin, etc., which were used both for topical and systemic therapy with advantage. The discovery of penicillin by Sir Alexandar Flemming in 1942 followed by host of other antibiotics in such large varieties and numbers further revolutionized the treatment of infective systemic and dermatological diseases. Some of these antibiotics were soon found to be very effective when used internally e. g., penicillin, streptomycin, tetracyclins and chloramphenicol. The local use of some of them resulted in producing contact allergy as in the case of sulphonamides. Some other antibiotics were added for local use such as tyrothrycin, gramacidin, neomycin, etc. Still further advantage in the management of skin diseases accrued when steroids came to be used with astonishingly good results both when given internally or used locally on the skin, in a large number of allergic and inflammatory disorders from various causes. A combined use of antibiotics and steroids became a great factor in the therapy of skin diseases including some caused by immune complexes or even some others of unknown etiology. The topical use of antihistamines however fell in disuse due to sensitisation caused but their systemic use became a powerful weapon to control sensitisation dermatoses and for symptomatic relief of pruritus.

Some further impact was noticed during the second world war when using antimalarial drugs to control malaria it was found that photo dermatosis in some of these patients was equally beneficially improved — thus adding a method of treatment in diseases of skin caused by photoallergy to different bands of solar spectrum.

Recently use of immuno suppresive drugs alone or in combination with steroids has controlled many incurable maladies. There have been many further advances in therapy with the use of improved anti-tubercular and anti-leprosy drugs and recently by use also of sulphamethoxol, and trimethaprim. Today therefore, the management of skin disease is not a frustrating adventure but a positively good and rewarding expectation with judicious use of the new drugs. All the old methods of intravenous arsenical preparations and calcium, intramuscular use of gold and bismuth or of auto-haemo-therapy and milk injections have been relegated to the past.

Improved method of diagnosis

Just as in therapy so also in investigative pursuit of precise and correct diagnoses or in understanding of the pathogenesis of the disease process, improved methods have fortunately become available with the advancement of other sciences and their applications in medical research.

Today dermatology has passed out of the realm of clinical study of macroscopic changes of the lesions to a field of study based on advanced histology and electron microscopy. The study of cell anatomy in all its minute details, cell chemistry and enzymology correlated with functions of cell organelles has pre-eminently added to our knowledge and understanding of the

the disease process and a rational approach to its management. There are far advanced and improved methods available today to study the behaviour of tissues and cells confronting the stimulii of infective agents, physico-chemical and environmental changes, allergens and also immune processes by experimenting on tissues and circulating cells with their immune reactions produced in biocultural or of immune-globulins with circulating antibodies. In fact the search is as much against the tissue responses with individual variations as it is against the causative agents. The field of research for a young dermatologist has become vast and challenging.

Research problems

It is for the new generation to take up this challenge, and we are fortunate indeed, to find, that in our country some of the younger generation, have given a good account of themselves in undertaking such investigative pursuits. The need for them is to seek the right problem mainly connected with our national health priorities. It is good to work on basic problems but obviously it is better and more urgent to occupy oneself with problems in hand and give them priority. More work in this country is needed to be done on nutrition and skin, communicable dermatoses (which includes bacterial, fungal, protozoal diseases of skin as also dermatoses caused by arthropods like scabies and pediculosis which have been seen in epidemic proportions). Special attention is needed to be given to leprosy in national priorities. Research is also to be conducted to assess the efficiency of existing and traditional remedies and to know their scientific basis.

Teaching

Dermatology did not find its due place in curriculae of medical teaching. A few lectures in some institutions were given mostly by teachers in department of medicine. It was during the second world war when the quantum of morbidity due to skin diseases in the troops and in uprooted populations was discovered and made it necessary to upgrade this speciality and wean it from general medicine in the same manner as orthopaedics and plastic surgery were upgraded and taken out of the field of general surgery. After the war there was a spate of medical graduates who went overseas for post-graduate training in various fields of medicine and surgery as till then a good facility for postgraduate education in this country did not exist. Some newer specialities within general medicine in overall administrative set-up were created such as chest disease, gastroenterology, haematology, endocrinology etc. but dermatology and psychiatry were kept out to develop separately for reasons which were not convincing to many. In the case of dermatology some other facts had to be reckoned with, such as (a) whether the speciality should be taught alone, or in a compositive manner along with traditionally combined subjects of venereal diseases and leprosy, (b) whether the training of a dermatologist be preceded by his taking M. D. examinations in medicine or whether his train ing could offshoot separately after medical graduation OR — how much medicine training was necessary at all, (c) whether diploma examination in the subject was sufficient or whether there should be M. D. Ph.D. as an objective of postgraduate training.

These problems were discussed in detail in Universities, in institutions and Medical Councils of India taking note also of the situation as it existed in various countries abroad. In 1964 the Medical Council of India brought out a consensus of opinion that depending upon our own needs and job availability the subject of dermatology be treated as a combined and broad-based speciality

including the subjects of venereology and leprosy with an M. D. examination of its own. There were, however, adjustments made later on by Universities and the National Academy of Medical Sciences to let those institutions and States finding it more convenient to teach the speciality separately from venereal diseases and leprosy continue to do so. It, therefore, does not matter what method is followed but the main point is to direct our energies in meeting the challenge in substance and to increase our potential and facility for further improvement in teaching and research in all our institutions guided by our national health requirements and needs. The problems that face us in reaching basic health needs to all our population particularly in the villages require us to make available, speciality services in the same manner to high incidence pockets in both urban and rural areas as far as possible. The prime need is to combat and contain the increasing numbers of communicable diseases in our field, particularly leprosy, venereal diseases and skin infections.

Our government and authorities are aware of these existing and urgent national problems, and have provided funds to meet the facilities in this direction. This should be utilised to maximum advantage with stress on prevention and community health and mass scale treatment rather than on treating an individual patient.

Our institutions and our association should adopt villages, and high incidence pockets of urban populations to be tackled in a big way by an efficient medical aid and of increased education of the general populace and of medical personnel.

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— *Managing Editor*