PATTERN OF SKIN DISEASES IN KARACHI-PAKISTAN.

By
NUSRAT ALI SHAIKH, M. R. C. P.,
Director, Central Skin and Social Hygiene Centre, Karachi

Karachi has been the capital and the premier port of Pakistan since partition of the Indian Subcontinent in 1947. Its population has increased tremendously since then partly on account of it being the seat of the Central Government and partly due to Industrialization. Before any attempt is made to discuss the principal dermatological conditions it is worthwhile describing the georgraphical peculiarities of this city and its weather conditions because these in my opinion have a direct bearing on the pattern of skin diseases. To the south of Karachi is the Arabian sea and in the North-east it is surrounded by the relatively desert area of Sind which is a continuation of the Rajasthan desert. However, because of its coastal location and the prevailing winds, humidity gets added to the warm weather of Karachi. The summer is very long, beginning from the latter half of March and continuing upto the end of October. Winter is not only short but very mild. Rainfall is scanty and occurs during the Summer Monsoons in the months of July and August.

Due to lack of education the patients do not report for treatment unless compelled by the severity of symptoms. The average yearly attendance at the skin hospital of Karachi taking into account the figures of the last 4 years is 33,000 males and 21,500 females. The attendance declines during the winter months when in January it is as low as 2100, but it rises again steadily during Summer. The peak attendance is reached in July and August when an average of 6000 cases report for treatment each month,

Although the skin conditions that we see in our country are different from those seen in temperate climates, it is unlikely to show any major differences from the pattern that one comes across in similar cities of India.

Most common skin diseases for which the patients attend our skin hospital are bacterial infections consisting mainly of Impetigo and Furunculosis. This group constitutes 25% of the total attendances. Males and females are affected in equal number. The number of these cases increases from the month of May onward. The peak usually being reached in July and August. During these months the already high relative humidity of Karachi sharply increases on account of the Monsoon rainfall. This results in the development of prickly heat which in the majority of cases precedes these pyogenic infections. With the decline of summer, cases of such infections also get less. Inpetigo and furunculosis are most commonly seen in young children between the age of 1-3 years. This is borne out by the fact that out of an average yearly attendance of 13,100 cases 10,800 have been in the above mentioned age group.

Next in the order of frequency during the summer months are the various superficial fungus infections of the skin. The pattern of this disease is also similar

to that of bacterial infections. Cases of Fungus infections begin to rise from the month of May. There is however, a sudden and sharp rise in these cases during August, September and October. The males outnumber the females in the ratio of 4:1 as is evident from the average yearly figures of 2,850 males and 680 females. Most of the cases in the later series have been in children suffering from Tinea Corporis. Due to such a high number of cases of Fungus infections apart from the routine examination of scrapings no detailed culture examinations are done. Amongst the males the majority present with Tinea Cruris and Tinea Pedis. A noteworthy feature amongst women is that Tinea Cruris has been very rarely seen at our hospital. We have only seen 42 cases of Tinea Cruris in women during the last 4 years. This fact distinctly commends itself to observation inspite of the reservation that our women folk by virtue of their household preoccupations and natural shyness, may have to visit the hospital.

Pityriasis Versicolor is another common Fungus infection but the majority of patients suffering from this disease present with the hypopigmented scaly variety. This type of fungus infection has most commonly been seen amongst the young males.

Favus: is very uncommon in Karachi. Only 8 cases have been seen in our Hospital during the last 4 years. All of them have been amongst people who have migrated either from Kashmir or the former N.W.F.P. of Pakistan.

Tubercular Infection of the Skin: Although Tuberculosis of the internal organs especially of the lungs is fairly common, it is surprising that skin Tuberculosis is rather uncommon. On an average 40 cases of Tuberculosis cutis are seen during the course of one year. Most of these cases being either of Lupus Vulgaris or of Tub. Verrucosa Cutis. Scrofulodermia on the other hand is uncommon, probably due to the early diagnosis and effective treatment of the underlying Tubercular disease with chemotherapeutic agents. It is also possible that some cases of scrofulodermia may be attending the surgical departments for treatment. The overall low incidence of Cutaneous Tuberculosis as compared to the common Tuberculosis of the lungs and other internal organs may perhaps be due to plenty of sunlight that we get, resulting in the formation of lot of Vitamin D which protects the skin against such infections.

Scabies: During the winter months the commonest disease seen by us is Scabies. The propagation of this disease is helped by unhygienic and overcrowded living conditions. There is a sudden and sharp rise in the incidence of scabies during the winter months of December and January, when almost 30% of the new cases report to us for the treatment of scabies. We however, continue to see this disease even during the summer months although the number of these patients is very small.

Eczema: This disease is responsible for about 13% of our total new cases. Although rapid industrialization has taken place in this city, the number of cases suffering from contact dermatitis which have reported to us for treatment is

comparatively low. The contact reactions that we have seen, have in a very small proportion been due to industrial causes and mainly due to the injudicious application of some medicine either through ignorance of the patients or through receiving treatment from quacks.

Seb. Dermatoses: The incidence of this group runs almost parallel to the eczema, constituting about 10% of patients.

Cases of Seborrhoea Capitis however, outnumber those of Seborrhoeic Dermatitis. An interesting feature that we have noticed is the association of chloasma like pigmentation of face when Seb. Capitis and Seb. Oleosa of face are present.

Psoriasis: Contrary to the normal belief that Psoriasis is very uncommon in the tropical countries, we have seen an average of about 300 cases per year. The males in our series have outnumbered the females in the ratio of 3:1. It is intersting to note that itching was complained of as a symptom quite commonly. Psoriasis Arthropathica appears to be a rarity because we have been able to see only 5 cases during the past 4 years. It is again possible that these cases attend the orthopoedic departments on account of the disability caused by the arthritic condition.

Lichen Planus: An average of 235 cases of Lichen Planus seek treatment every year. Males are affected slightly more than the females. Severity of the disease varies from a few isolated papules to severe extensive erruptions covering the limbs and trunk. The lichenoid erruption due to mepacrine has hardly ever been seen by us. During the last 4 years I have seen only one case of this type. This may be due to the fact that malaria is not common in Karachi and therefore anti-malarials are not much used.

Leishmaniasis: This again is not a common condition in Karachi. Only 1/2 a dozen cases are seen per year at our hospital and almost all of them have come for treatment from the Makran and Lasbela States which lie to the north of Karachi.

Lupus Erythematosus: An average of 34 cases of Lupus Erythematosus are seen by us every year. In our experience the females have been affected twice as frequently as males. I have seen only 3 cases of disseminated Lupus Erythematosus during the last 2 years.

Conclusion: In Karachi we have a set pattern of dermatoses influenced considerably by the climatic condition of the city, and the socio-economic circumstances of its people. Diseases like Impetigo, Furunculosis and superficial fungus infections are common during the summer and Scabies seborrhoeic eruption especially of scalp are common during the winter.

The low incidence of Cutaneous Tuberculosis has been noted. Similarly very few cases of Tinea Cruris in women have been seen by us.