5th ALL INDIA CONFERENCE OF DERMATOLOGISTS & VENEREOLOGISTS

PRESIDENTIAL ADDRESS.

By
V. GOVINDA NAIR.

Fellow Delegates,

I am very. grateful and thankful to the members of the Indian Association of Dermatologists and Venereologists for having elected me as the president of the Association. I consider this a proud priviiege and great honour. You will forgive me if I do not come up to your expectations; I am only a silent and humble worker. I hope your indulgence, kindness and sympathy will overlook my shortcomings. I may, however assure you that my humble services are always at your disposal and I promise to do my best.

NATIONAL EMERGENCY.

We are meeting under the shadow of an unprecedented national emergency in the history of Independent India. You are aware that this emergency was caused by the unscrupulous and deceitful aggression of a so-called friendly neighbour, viz. Red China, returning evil for good. Our stand in this crisis is crystal clear. We, as nationals of our mother land, should place unquestioningly our services at the disposal of the Government, besides making liberal contributions in money and gold. Those of us who are young should join the Defence Services and those who are old should take the place of those young officers in service who may be drafted to the army. So I suggest that a list of volunteers from among the members of our Association be prepared and submitted to the government. I appeal to one and all, whether present here or not, to enlist as volunteers.

HOMAGE TO THE LATE Dr. B. C. ROY

We are meeting today in this wonderful city of Calcutta, a city of palaces and plenty and a former capital of India. This city of history added lustre to itself by adopting our national hero, a physician of international repute and a politician of a high order, who steered the state of Bengal through very difficult times, as its chief minister for over a decade. Let me pay my humble homage to the memory of this great doctor-politician Bidhan Chandra Roy who lived and died for this city, this state and for India. On behalf of you all, on behalf of our Association and on behalf of my humble self, let me place on record our heart-felt condolences on his sad demise. May his soul rest in peace. In his death, our country has lost a distinguished doctor and a great patriot.

CONFERENCE

Today is a red letter day in the annals of our Association and the other six sister associations that are meeting here under the auspices of the Association of Physicians of India. This is a very unique occasion. I hope and pray that this

mutual understanding, fraternity and cooperation will continue. It is like meeting of the wedded daughters at the house of their great mother for the annual festival of Deepavali, a festival of lights.

Our Association is thankful to the organisers of this Seminar of conferences or the confederation of specialist associations as well as to the authorities of the Association of Physicians of India, for giving us this opportunity to take part in this confederation. We are all aware of the difficulty of organising and conducting an annual conference of even one association. So, we can imagine the trouble and difficulty gone through by the organisers and the time and energy spent by them. We are also grateful to them for the fine accommodation and other amenities provided. The organisers have done a wonderful piece of work and we appreciate their noble and selfless work for the cause of Medicine. May god bless them.

OUR ASSOCIATION

Though the association was started in 1947 and the first conference was held the same year in December, this is only the 5th conference, the other conferences being held in April 1951, Dec. 1956, and Feb. 1962 at intervals of about five years. This is the first conference to be held with an annual pattern and I hope we will continue this pattern in future.

Our membership is necessarily small, being a specialist association with very few practising specialists in the country. So I appeal to all those who practice the specialities of dermatology, leprology and venereology to enlist themselves as members, if they have not already done so. It is depressing to note that the Dermatologists and Venereologists of this large city and the state of which it is the capital, have seceded from the parent body and have set up separate Association of Dermatologists. So from this platform, my appeal and my humble request go to them to return to the common fold and to give us the pleasure of their company and their full moral and material support to make this a united strong and vigorous association.

There is doubt in the minds of some of our collegues, why the specialities of dermatology, venereology, and leprology be canbined into one of dermatology and Venereology leaving the appellation of leprology completely out. So I commend to you for consideration the name 'The Indian Association of Dermatologists, Leprologists and Venereologists'. It may be permissible for each speciality to hold clinical meetings separately, if necessary, as done in Bombay.

OUR JOURNAL

Our Journal is slowly improving, thanks to the Editorial Board and the Managing Editor. I hope and trust that the members will take a more lively and abiding interest in the Journal and see that every member contributes at least one article every year and particularly the teachers in the medical colleges.

MEDICAL EDUCATION

About the teaching of dermatology, this is what the Editorial in The Practitioner of May, 1962 wrote. "The subject is so badly taught in our medical schools;

not because of any fault on the part of dermatologists but merely because it is now relegated to such an unimportant place in the medical curriculum. In view of the preponderant part dermatology plays in general practice, a little more dermatology and a little less surgery in the curriculum would make life a lot easier for the general practitioner and their patients." If this is the state of affairs in such an advanced country as the United Kingdom, you can very well imagine the condition in our country in all the three subjects we represent.

So, as a representative Association of Dermatologists, Leprologists and Venereologists, I deem it necessary that this Association should decide the syllabus, curriculum, the extent of the course, theoretical lectures and attendance at clinics for lecture-demonstrations and if possible a skeleton of the lectures and demonstrations and year of study for these subjects for undergraduates and post graduates should also be drawn up. As the curriculum of studies for the undergraduates is over crowded, the Association may also consider whether the teaching of all or any of these subjects can be conducted during the period of internment or House-Surgency.

Decision has also to be taken regarding the type of postgraduate qualification requirad. Two such qualifications are found necessary.

(i) A postgraduate degree of the status of Doctorate for teachers in the medical colleges and teaching hospitals.

(ii) A diploma of shorter course, providing competency for running the district, taiuk and other hospitals, with a refresher course for these, every five years.

Subcommittees have been appointed to consider these questions and their reports may be considered and decision taken by this conference.

Being an association of experts, I feel that the Association should take definite steps.

(i) To publish standard courses of treatment for the common conditions in specialities for the benefit of the general practitioners, students and junior specialists.

(ii) To publish a book on Indian dermatology with correct description of the manifestations as seen on the Indian skin. This is very essential, as the description and coloured pictures in foreign text books refer to the white skin.

(iii) To take measures to see that clinical laboratories are run by specially qualified and experienced doctors and not primarily by technicians. It is very undesirable that serelogical tests, such as Wassermann, Kahn and such others, are done by technicians who are not qualified and not competent to do them. These tests should be done only in such laboratories where a minimum of specimens are done every time. Laboratories where only three or four specimens are done at a time should not be allowed to continue.

Spurious drug trade and the way medicines are advertised deserve our consideration and a lead from us. Dr. Wallace in The Practitioner of May, 1962, writes about the drug advertisement which was also endorsed Editorialy, " The persistance, inspite of many protests of grossly unscrupulous, indeed amoral advertising in the press, on the Radio and television is a sinister feature of our times and suggests that reform of the law in this respect is long overdue. Both in advertising and in personal interviews, these so-called hair specialists batten on the fears of the laity, deliberately ignoring the natural history of scalp disorders. In addition, the erroneous conclusions drawn from animal experiments are paraded to sell highly expensive and equally useless preparations." It is high time we looked into this subject and gave a lead to the public and the Government.

DERMATOLOGY

Dermatology has made great strides during the last few decades. The skin is the largest organ of the body constituting 16% of the body weight. Importance of the skin will be realised if we remember its high lineage. The skin is one of the wonders of creation. It is the most extensive organ of the body and covers in an adult about 3000 Sq. Inches. An intact epidermis is a powerful first line defence against the unscrupulous invaders, the micro-organisms which are always waiting for an opportunity. Millions of micro-organisms are found on the skin and yet we are saved from them by its protective function. By the action of proteolytic and lipolytic enzymes produced by these saprophytes, on the secretions of the skin an odour is produced in health and disease. The skin also synthesizes one of the most important vitamins–Vitamin D, using the energy of sun's ultraviolet rays on ergosterol which has the same structure as cortisone and sex harmone. The skin is a two-way organ; it not only receives impressions, but itself forms one of the main organs of expression. We become pale with fear and red with anger. It is perpetually renewing itself and responding to every change of mood and circumstances. "The skin is an inseparable part of the whole person, whose organs and emotion affect each other, and whose function and moods are often shared by or reflected in his skin. "The skin is its owner " and the owner is an individual with genes, a family and a physical and social environment; and as the individual changes from infancy to old age his skin changes with him. Thus dermatology is more than skin deep; it is concerned with the whole, constantly changing person." (John Apley).

The new born infant does not react to flea bites, but papular urticaria is commonest in children. Warts also are commonest in children. Fungus infection of feet is rare in children but common in young male adults. Ringworm of the scalp due to M. audouini is a common affection of the children but almost unknown in adults. Herpes zoster is generally accompanied by severe pain in adults and more in old people but almost never in children. So also post-herpetic neuralgia is severe in old people less in adults and never in children.

At puberty, the apocrine sweat glands begin to function, oiliness of the skin develops and is associated with acne. At every age the host plays an important part in determining what from the disorder will take.

This organ created interests in the physicians from ancient times. The total number of diseases the skin is liable to is 483 (A. S. Thambiah).

The advances in dermatology have been in many directions.

1. *Clinical:* New developments such as industrilisation and trade and modern methods of life and environment have produced new diseases such as occupational dermatoses, contact and allergic dermatitis etc., which require close study.

2. *Histopathological & Histochemical:* Histological studies of biopsy materials from patients suffering from collogen diseases by combined Alcian Blue - Feriodic Acid - Schiff Stain have shown that these diseases can be differenciated. This staining technic differentiates systemic lupus erythematosus and dermatomysitis from the other collagen diseases as scleroderma and periarteritis nodosa.

3. *Biochemical:* Bloch (1916) observed that skin sections stained by dopa (Dioxyphenylalanine) showed increased pigment in certain cells, melanoblasts. Later, it was found that there is in the skin a copper-combining enzyme, tyrosinase which is able to convert the aminoacid tyrosine-to dopa and dopa to melanin. The pellagra toxin also is the same "dopa oxydase". Disturbances of enzyme mechanisms as cause of disease is now engaging the attention of the biochemists.

4. *Mycological:* A variety of fungi affect the skin. Their identification by the microscopic and cultural studies has become a routine necessity, particularly after the advent of the new oral anti-fungal drug, griseofulvin. This drug is found to be very effective in supperficial ringworm affections of the skin, hair and nails. It is effective only in infection with Microsporum audouini and M. canis, Epidermophyton floccosum and all types of Triceophyton. But it has no effect on other fungi, particularly against Candida albicans. But we come across instances of griseofulvin prescribed for all kinds of diseases, both fungal and non-fungal. This drug was used by the W. H. O. for mass treatment of ringworm of the scalp, in Yugoslavia, with 85% success. It has little or no adverse side-effects. In spite of this high effectiveness, recurrences are frequent. Fortunately for us ringworm of the scalp is rare, particularly in South India. At Vizagapatam, I was not able to see even a single case during a period of 15 years. It is also absent in Kerala. In a series of 100 cases examined microscopically, almost every case showed only Epidermophytom floccosum which does not affect the hair. Mycological studies are necessary to determine the nature of the infecting fungus and such studies may also lead to the discovery of new anti-fungal drugs.

5. *Allergy:* The vastness of the subject is forcing it to be made into a separate department. In many cases of allergy, the skin manifestations take a

prominent place and so the dermatologists have to take a major share in investigating and treating a multiplicity of conditions. It is claimed that 11.8% of the new cases attending a dermatology department are allergic. (S. C. Desai)

6. *Therapeutic*: A number of new drugs and new methods and lines of treatment have enriched the armamentarium of the dermatologists. Amongst the drugs may be mentioned chemotherapeutics, hormones, widespectrum antibiotics, cortico-steroids, tranquilisers, etc. The other lines of treatment are X-rays, ionised radiation, derm-abrasion, plastic surgery, etc. Though some of the diseases can be cured or alleviated by these new drugs, they have also produced many new conditions on the skin as side effects. But in spite of all these advancements, treatment for many common conditions of skin still remains a problem; warts, urticaria, folliculitis, pruritus, lichen, psoriasis, vitiligo, pemphigus are some of them.

It should be remembered that psychc-therapy too has an important place in the treatment of skin diseases.

7. *Investigative Dermatology:* This is already established in many countries, though we have none in our country. We are ignorant of the aetiology, pathogenesis and treatment of many diseases. So, they require full investigation and further study. Hence, investigative centres may be established in at least some of the postgraduate centres of medical education. That is a thing which we must work for with all our weight.

LEPROLOGY

Leprosy is an ancient and global disease. Egypt is considered the original home of leprosy. The great Ayurvedic physicians of India recognised it and Charaka described leprosy fairly accurately. The world total of persons suffering from leprosy is estimated at 10 Million, out of which India has about one to two million. Of these, about 250,000 are estimated to be lepromatous.

It is obvious that isolation or segregation of all the infectious cases of leporsy is difficult. But, we can certainly isolate the smaller number of children, both tainted and nontainted, of persons suffering from infectious leprosy. It is the policy and objective of the Union and State Governments to give compulsory, free, universal, primary education. I humbly suggest that the governments take one more forward step and provide free hostels also for these unfortunate children of those suffering from infectious leprosy. That will uproot and dislodge leprosy from our country. If every Community Development Block puts up semi-permanent hostels for both tainted and nontainted children, the problem of leprosy in our country will be solved in a decade or two. The segregation of these children is said to have produced no appreciable result. The secret of success depends in not removing these children far away from their parents. The children should not be isolated more than 4 or 5 miles away from their parents so that they can visit their children as often as they like.

Modern clinical account of leprosy by Boeck appeared in 1847 and in 1871 Hansen discovered the bacillus causing leprosy, now known as Mycobacterium leprae. But so far, the organism has neither been cultured nor a susceptible animal found for experimental purposes.

For a long period, the accepted teaching was that M. leprae can be demonstrated only in the lepromatous lesion and it was absent in the maculoanasethetic or neural patches. About 25 years ago, Govindan Nair and Pandalai were able to demonstrate M. leprae in neural patches and smears from the nose and ear lobes. The Indian Journal of Medical Research and the International Journal of Leprosy refused to publish the paper recording their findings and returned the paper with the remarks that the classification adopted was wrong. Eventually, the paper was published in the Journal of The Indian Medical Association. Now it is universally accepted that M. leprae can be demonstrated in non-lepromatious lesions and even in normal skin of contacts though not in large numbers, nor by the standard method of examination.

In recent times, development in clinical, histo-pathological, bacteriological and immunological aspects of leprosy has taken place Among a number of research workers in our country in the field of leprosy, two outstanding personalities compel our respect. They are Dharmendra and Khanolkar. The former has been a lifelong student of leprosy and has made numerous contributions in all aspects of leprosy. Khanolkar, a pathologist of Global fame has given us his concentration method and special stain with auramin " by which acid-fast bacilli from almost all the lesions of active and even quiescent leprosy " can be detected. He was also able to demonstrate how M. leprae after entering the skin were taken up by regenerating nerve fibres, multiplied in the axoplasm of the nerve fibres, entered the Schwann cells and lay dormant there and how at an opportune moment they proliferated and were carried away by the histiocyte cells which were later transformed into either lepra cells or epitheliod cells depending upon the reaction of host to the presence of M. leprae.

Chaulmoogra oil, widely used by the ancient Aurvedic Physicians, was the drug of choice in the treatment of leprosy till 1940. In March 1941, Faget and his associates of the National Leprosarium, Carvile, La, were the first to try sulfones in the treatment of leprosy. Sulfones have since revolutionised the treatment of leprosy and replaced all other drugs, though Chaulmoogra oil and its preparations have still a small place reserved for them.

Reactions in leprosy, in both treated and untreated cases, occur. Reactions are met with in all types and all classes of cases. They may be mild on severe. But these reactions have become commoner after the adoption of sulfones as the routine treatment. I am led to think that the sulfones by their inter-actions on the host tissues and or on M. leprae may have something to do with the more frequent production of these reactions. Another possibility is a photosensitisation,

as more reactions are seen during summer. In the corticosteroids in small doses, we have a wonderful and efficient drug in controlling the reactions, but recurrences have also become frequent. In some cases, reactions reappear soon after the stoppage of the hormone.

VENEREOLOGY

Venereal diseases were originally a family of five. Recently, non-gonococcal or non specific urethritis and Trichomonas infection also are included. I am not sure about herpes genitalis or progenitalis, There is an unwarranted feeling among the lay and even the medical people that the venereal diseases are fast disappearing after the advent of penicillin. The number of cases attending the venereal clinics showed a downward trend all over the world in the postwar period. Since then, reports from U. S. A., Canada and U. K. show that there is an upward trend and particularly in the teen agers. American Social Health Association have released the information that early infectious syphilis in U. S. A. was up by 46% in the first 9 months of fiscal year 1960. W. H, O. in a report issued in September 1959 refers to a 'recrudescence' of venereal diseases in France, Finland, Italy and various areas in Africa.

Very remarkable progress has been made in our comprehension of the background and environment of venereal diseases, their manifestations, diagnosis and treatment. The subject is so vast to be considered here. So I shall place before this learned body some problems in venereal diseases.

(A) A joint report by three American Associations state that.

(i) Not even 1/6 of early infectious syphilis or 1/4 of gonorrhoea in U. S. A. are discovered and treated.

(ii) For the country as a whole, 1959 increase in venereal diseases among children between 10 and 14 was 14.3% and for those between 15 and 19 it was 11.4% over 1958.

(iii) Among all age groups, the number of cases of early infectious syphilis had risen from 6661 in 1958 to 8178 in 1959- an increase of 22.8%.

(iv) The number of gonorrhoea cases rose from 220,101 in 1958 to 237,318 in 1959, a 7.8% increase.

(B) American Social Health Association had released the information that early infectious syphilis in the U. S. A. was up by 46% in the first 9 months of fiscal year 1960.

(C) W. H. O. in a report issued in September 1959 refers to a' recrudescence 'of venereal diseases in France, Finland, Italy and various areas in Africa.

2. *Granuloma Venereum*: The confusion in the nomen clature of this disease is removed by adopting the new name " Donovanosis " in memory of Col. Donovan who discovered the causative organism-donovania granulomatis-and described it as a 'gigantiform bacillus'. The problems in this disease are (a) whether the causative organism is a bacillus, bacteria, protozoa or virus (b) the

histopathology some-times simulates malignancy. Do they really develop malignancy? Malignancy has not been noticed even in patients suffering from the disease for 20-30 years. (c) Whether this is a veneral disease? The disease is more predominant in women and the reported cases of both husband and wife being affected at the same time are rare. Personally, I have not come across even a single case of both husband and wife being affected at the same time, although I have seen a large number of these cases and examined the other partner also. (d) The ulcers, though extensive and unattended to, it is interesting that there is no super added pyogenic infection nor any regional lymphadenitis.

No specific atigen is available for intracutaneous and complement fixation tests. But, at Vizagapattam, Pandalai and Govindan Nair prepared an antigen from the granulomatous tissues removed from patients showing donovan bodies which was used for both cuti and complement fixation tests. As the results were not specific and facilities for continuing the work were absent, it was not pursued.

The disease is said to be more common among the Dravidians. It is interesting that the Dravidian Muslims are practically not affected due to circumcision done during childhood.

Lymphogranuloma Venereum: Diagnosis of this disease in all stages has become a problem. The infecting virus is not easy to be demonstrated in smears, to be culfured in the chick embryo, or to be isolated by mouse inoculation. The antigen for the diagnostic intracutaneous Frei test is not available. The change in the pattern of blood proteins is not diagnostic.

The treatment of the late manifestations, particularly stricture rectum is also a problem as the radical operation of resection of the stricture bearing area is a serious one.

3. *Chancroid*: Here again, the diagnosis is a problem. H. ducreyi, the causative organism, is difficult to be demonstrated in the smears or to be cultured. Demelcos Vaccine with which the intracuti diagnostic test is done is not available. Hence the diagnosis depends on a process of exclusion or on therapeutic test.

Gonorrhoea: Has lost all its terrors. The old adage "once gonorrhoea, always gonorrhoea" has lost its significance. The problems in gonorrhoea are recurrent infections, and non-gonococcal urethritis in both the sexes and vaginitis in the females, caused particularly by Trichomonas vaginalis. So the culture of N. gonorrhoeae for diagnostic, immunological and for testing the sensitivity of various antibiotics have become a necessity. As the Trichomonads lie dormant in the prostate, special attention should be paid to the prostate in the management of these cases. The treatment of these cases was also a problem, but after the introduction of "Flagyl, metronidazole (M/s. May & Baker), the problem seems to have been solved for the present. Candida infection is becoming more common, particularly in pregnant women. Women seem to be carriers of both Trichomonas and Candida.

5. *Syphilis*: There are many problems in syphilis.

1. Syphilis may be venereal or non-venereal.

2. All exposed to syphilitic infection do not acquire the disease. Some prostitutes exposed to infection for many years have escaped the infection.

3. Sex, age and race have some influence in the course of syphilis. Syphilis takes a more bening course in the female than in the male. Pregnancy and lactation also play an important part in the defence mechanism of a woman against siphilis. Moore was able to demonstrate clinical suppression of syphilis by pregnancy.

Age: A foetus infected in utero, often succumbs to the acute infection. But an adult with acquired syphilis seldom dies of acute infection.

Race: In America, cardio-vascular syphilis is more common in the coloured than in the white patients, and the reverse is the case with neuro-syphilis.

4. There is a effective localisation of syphilis in some of the tissues of the host. Some patients after 20 or more years after infection show affections of the bones, joints, central nervous system, etc. I have observed in the secondary stage, when the skin is affected profusely, the mucous membrane escaped and vice versa. Interstitial keratitis is a constant feature of congenital syphilis. The tissues of the lymphatic systems and testis seem to be definitely spirochaetotropic. Ano-genital, mouth, throat region and the eye are sites more vulnerable to relapsing lesions. In the Oslo study of untreated syphilis, 86.8% of relapsing lesions were on these regions. Thus, there seems to be a tissue susceptibility in the host. The problem is highly complex and important.

5. Reaction to treatment is different in different patients with fairly adequate treatment may show relapses or latent lesions after some years. Others with even inadequate treatment are free from the disease clinically, serologically and Roentgenologically. Similarly, serological negativity is reached and maintained after some treatment not fully adequate, while others continue to be serologically reactive even after adequate treatment.

6. The nature of the gummatious reaction is astonishing. A few T. pallida are able to produce a violent destructive lesion in contrast to the non-destructive but proliferative reaction in secondary syphilis, when the skin and tissues are overwhelmed with organisms.

7, There is no immunity in syphilis.

8. Of late, there is a decline in manifest early syphilis and a progressive toward trend of latent syphilis. Could it be due to the use or abuse of penicillin in general practice ?

9. Has potasium Iodide any place in the treatment of syphilis? Boecke was a firm believer in it. Brown and Pearce had observed that on experimental animals, it exerted an increasing resistance to syphilis.

10. Are there spontaneous recoveries in acquired and or congenital syphilis? Jeans & Cooke state that they had seen 12 instances of apparent spontaneous recovery in children, first seen during early infancy and 20 others in children first diagnosed after two years of age.

11. Older mothers with long standing infection give birth occasionally to healthy children even though their serological tests are strongly and repeatedly positive.

12. Has treatment of early syphilis, adequate or inadequate, any influence on the incidence of neurosyphilis and cardiovascular syphilis? It is said that even inadequate treatment of early syphilis gives considerable protection against the development of cardiovascular syphilis, but seems to have no effect in the prevention of neurosyphilis.

13. Third Generation Syphilis :- It is very difficult to satisfy all the conditions for the acceptance of 3rd generation syphilis. According to Nabarro congenital syphilis in the mother played a not inconsiderable part in its incidence. He thought that it was certainly possible for a woman with untreated congenital syphilis to have congenitally syphilitic children by a healthy husband. I have had occasion to see a number of congenitally syphilitic mothers having congenitally syphilitic childeren. Most of these patients had been coming from the obstetric department for the treatment of their babies with congenital syphilitics themselves. The husbands of these congenitial syphilitic mothers were examined wherever possible and found to be clinically and serologically negative for syphilis.

14. Cardiovascular syphilis in congenital syphilis is extremely rare but neurosyphilis is not infrequently seen.

15. "Uncomplicated aortitis" - Can this condition be clinically diagnosed or is it only suspected?

16. "Précocious tertiarysm" – Does this occur only in inadequately treated early syphilis?