Letter to the Editor

Urea in wound healing and acute mononeuritis of leprosy.

Dear Madame,

Urea has been used extensively as a denaturing agent in protein chemistry[1]. It also exhibits antibacterial effects[2]. As it is freely soluble in water we used a 20% solution in the treatment of chronic ulcers located in the paramalleolar region. All the subjects were adults and had their disease for at least 4 years. In all patients the ulcers showed unhealthy granulation tissue with variable purulent discharge. All of them had failed to respond to conventional treatment and many, even to several auto skin grafts (Fig. 1). Gauze pieces soaked in the solution

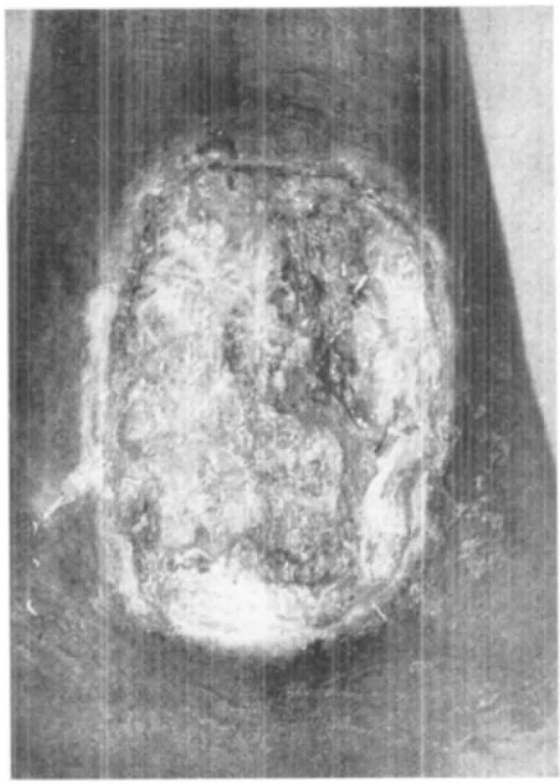

Fig. 1 Chronic ulcer (etiology unidentifiable after 4 years) on the medial malleolus. Square shape is the result of repeated surgical preparation for skin grafting.

were placed over the wound and kept in position with sticking plaster. Dressing was changed thrice a day. Healing began in 3 days and was complete in 21 days (Fig. 2). A firm pressure bandage over the scars was necessary for several weeks, to prevent breakdown. The healing effect of urea is clearly due to above actions, leading to softening of the base and clearing of infection.

Recently we treated an acutely inflammed ulnar nerve of a dimorphous tuberculoid reaction, in an adult male with 50% urea solution applied as described above, to the skin over the nerve. Pain disappeared in 24 hours and tenderness in 3 days. This effect is possibly due to lipoid solubilising action of urea on the stratum corneum leading to its penetration through the epidermis, thus setting up an osmotic effect on dermal edema.

Fig. 2 Healed ulcer of Fig. 1 after treatment with 20% urea solution for 3 weeks. Note healing and scar formation.

It is of interest that this patient had not responded to a combination of 30 mgms. of prednisolone, 300 mgms. of clofazimine and thalidomide each, per day, given for 3 weeks, prior to urea applications. He, however, did develop an irritant dermatitis (Fig. 3) which had to be treated later.

References

1. Swanbeck G: The effect of urea on the skin with special reference to the treatment of ichthyosis, The Ichthyoses: Marks R, Dykes PJ: MTP Press Ltd., Lancaster 1978; p 163.

2. Wilkinson DS: Topical therapy, Textbook of Dermatology 3rd Ed Rook A, Wilkinson DS, Ebling FJG; Blackwell Scientific Publications, Edinburgh: 1979; p 2293.

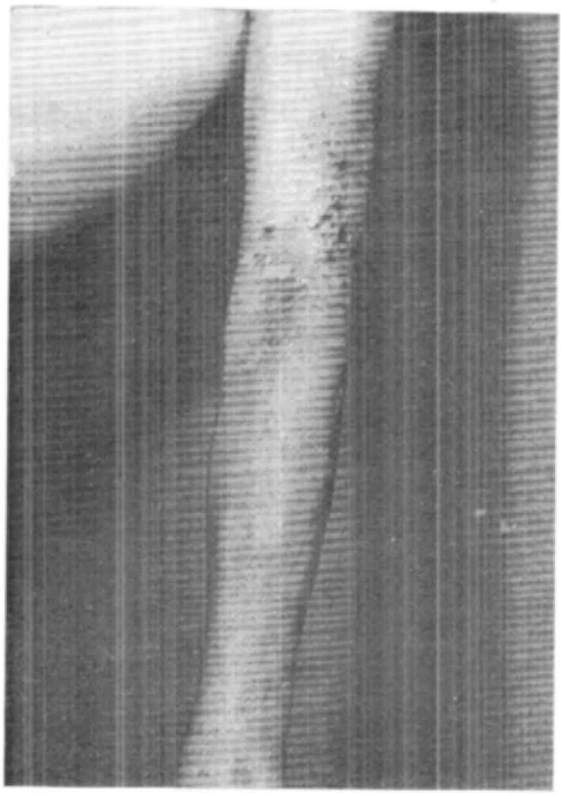

Fig. 3 50% urea solution causing irritant dermatitis but the acute mononeuritis of leprosy subsided.

Department of Dermatology,
Venereology and Leprology,
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Yours faithfully
V. R. Mehta and
Rekha Potdar

LETTER TO THE EDITOR

Dear Madam,

Dr. D. D. Ganguli et al published an article "A study of behavioural aspect of sexually transmitted diseases" in IJDVL 1983; 49 : 11-16. The authors discussed the age, marital and educational status, occupation, sex behaviour, alcoholism, promiscuity, source of infection, homosexuality and past history of STD. I think that the title should have been "the Epidemiological study of STD" because behavioural aspect was discussed in a few lines with one reference.

The learned authors wrote in the introductory paragraph that "a paucity of reports in the behaviour of patients attending STD clinics in the Indian scientific literature prompted us to undertake this study". They referred the work of eleven authors, out of which two were from India and one of these was of the authors. I think that this statement is not correct which was also overlooked by the Editorial board. I do not have access to a medical library at Bareilly (UP) but a few Indian authors[1-7] published their observations which were missed by them while discussing the subject.

Yours sincerely,

Military Hospital
Bareilly,
14 June 1983.

Lt. Col. TR Kapur, AMC,
Classified Specialist
(Derm & Vener)

References

1. Dubey PC et al : Vulnerability of Policemen to syphilis and gonorrhoea, Indian J Dermatol Venereol Lep, 1978; 44 : 206.
2. Hajini GH et al : Venereal diseases in Kashmir, Indian J Dermatol Venereol, 1975; 41 : 21.
3. Khatri ML et al : Clinico – epidemiological study of 26 cases of Donovanosis, Indian J Dermatol Venereol Lep, 1976; 48 : 38.
4. Nayyar KC et al : Personality profiles of VD patients, 1974; 40 : 218.
5. Ramadwar DK et al : A study of venereal syphilis in a high risk occupational group (Army recruits), Indian J Dermatol Venereol, 1974; 40 : 198.
6. Seth TR : Socio – Physical factors and incidence of VD, 1970; 36 : 93.
7. Sinha NP et al : Venereal diseases and alcoholic intake : Indian J Dermatol Venereol, 1974; 40 : 243.

To

The Editor,

Indian Journal of Dermatology, Venereology & Leprology.

Madam,

Epidemiology has been defined as the study of the distribution and determinants of disease in a population. It relates disease incidence to

1. The personal characteristics common to all those affected by a specific disease such as diet, social class, occupation or habits of life.

2. The time of disease onset in relation to contemporary changes e.g., in environment or habit, and the appearance of patterns in the timing of onset of cases within an outbreak.

3. The geographic or spatial distribution of the disease i.e., in relation to the physical environment.

It is apparent, therefore, that epidemiology and human behaviour are interdependent. As Green and Anderson[2] have stated "the relevance of human behaviour to community health is chiefly a matter of how human behaviour influences biological, ecological and epidemiological processes. The behaviour of individuals become the life-style norms of populations, which in turn influence the modeling and transmission of attitudes, culture and values, as well as diseases". Thus, many epidemiologic factors (such as age, race, occupation, marital and educational status, dietary habits etc.) influence human behaviour.

In the light of the above, we do not feel that any change in the title of our article[3] is warranted. Further the allegation that we have discussed behavioural aspects "in a few lines" is not true. Our article deals with some general aspects of human behaviour that might influence the acquisition of sexually transmitted disease. Sexual behaviour is but one aspect of human behaviour. Brief data on various other epidemiologic variables as age, marital and educational status, occupation etc. were presented not only with a view to delineating the characteristics of the population under study, but also because of their importance as determinants of human behaviour, and, more specifically, sexual behaviour. Promiscuity, alcoholism, homosexuality, the tendency to acquire repeated infections, and the sources from which infections are acquired are all linked with patterns of human sexual behaviour.

It was not our intention to imply that there were only two reports regarding the subject in Indian literature. Studies on the epidemiologic aspects of STD in our country are many but Dr. Kapur would surely agree that there is a paucity of reports

on the various behavioural determinants of STD in our country. The articles cited by Dr. Kapur were not missed; rather they were deliberately omitted as our article was not intended to be a review of either the epidemiologic or the behavioural aspects of STD, but to serve as a stimulus for further more detailed studies. In addition, the studies mentioned by Dr. Kapur were either limited to particular STDs (e.g. occupation-policemen, army personnel, etc). The validity of any conclusion drawn regarding their relevance to the general population or even an STD clinic population would, therefore, have been doubtful.

References

1. Reid DD & Hobson W: Epidemiologic Methods in the Study of Disease in Theory and Practice of Public Health, Ed. Hobson W Oxford University Press, Oxford 1979; p 50.
2. Green LW & Anderson CL: Community Health, The CV Mosby Company, St Dovis 1982; p 273.
3. Ganguli DD, Sundharam JA, Bhargava MC et al: A study of Behavioural Aspects of Sexually Transmitted Diseases. Indian J Dermatol Venereol Lepro. August 1983; 11-16.

FELICITATIONS

To

Dr. Bhanu S Verma, Professor of Dermatology, M.S. University, Baroda for being appointed as Honorary Physician to the President of India.

The venue of the next workshop on STD was decided to be at Cuttack and next Executive Committee meeting will be held at Burla.

Dr. F. Behera,
Hon. Secretary,
I. A. D. V. & L.

Prof. H. C. Mohanty,
President,
I. A. D. V. & L.

The 83rd Annual meeting of the Japanese Dermatological Association (JDA) will be held on June 8–10, 1984 in Sapporo, Japan.

For further information, kindly contact :

Prof. Takashi Aoyagi,
Sec. General,
Organising Committee of 83rd Annual Meeting of IDA
Dept. of Dermatology,
Hokkaido University School of Medicine,
N-15, W-7, Kita-Ku, Sapporo, 060, Japan

VIIIth National Conference of Indian Association for Study of Sexually Transmitted Diseases, 4th and 5th February 1984, Baroda.

Correspondence Address :
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'Nimb Nivas' University Road,
Baroda-390002.
Phone : Resi. 63600 Office : 55550

Delegation Fees :

Rs. 200/– for Consultants and Practitioners
Rs. 100/– for Postgraduate students
Late Fee of Rs. 50/– will be charged after 15-12-1983.

The XIIth Annual Conference of Indian Association of Dermatologists, Venereologists and Leprologists will be held at the Government Medical College Campus, Aurangabad (Maharashtra) from 19th to 22nd January 1984.

For details contact :

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Organising Secretary
Jadhav Mandi,
Aurangabad-431001