ORIGINAL CONTRIBUTIONS

PATTERN OF SKIN DISEASES IN KASHMIR REGION OF INDIA

AK Jaiswal, Gurmail Singh

In the nations of the developing world, the incidence of skin diseases is especially affected by geography. Epidemiological studies of skin diseases are important in the study of disease pattern, changes in disease pattern, and for planning dermatology services and research for a country. This report records the pattern of skin diseases encountered in Kashmir region of India. The incidence of the noninfectious dermatoses almost approximates that of infectious dermatoses in this Valley.

Key Words : Pattern of skin diseases, Kashmir, India

Introduction

The pattern of skin diseases differs in different countries and in different parts within the same country.[1] It is particularly so in India where religions, customs, climate and socio-economic status are so varied in different parts of the country. There are a few regional studies available from India, that shows that the pattern of skin diseases varies widely.[2-8] Kashmir the 'Paradise on Earth' is situated in extreme north of India at an altitude of 6000 ft. Climatic conditions vary from severe winters to moderately warm summers. Majority of the local inhabitants are Muslims and engage mainly in agriculture. Personal hygiene by and large is poor in those belonging to low socio-economic status.

From the Department of Dermatology and Venereology Base Hospital, Lucknow - 226002, India

Address correspondence to :

Dr. Col AK Jaiswal

This report unveils the first hand knowledge of the incidence and nature of dermatological disorders amongst local inhabitants of Kashmir and this is compared with that of defence personnel who are drawn from all over India having different ethnic, religious and social back ground.

Materials and Methods

The study population included 3600 new dermatological cases both from Armed Forces (2400) as well as civilians (1200) who reported to Srinagar military hospital Dermatology Centre during a period of two years. Diagnosis was made on clinical grounds and laboratory investigations where possible.

Results

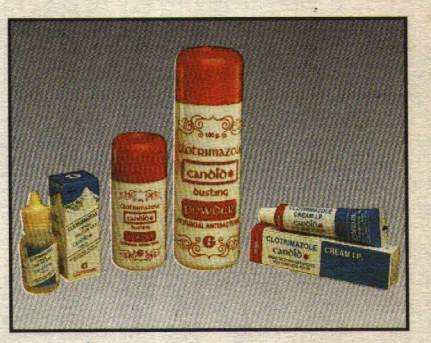
Tables I and II lists the groups of skin diseases and for each the numbers and percentages of patients seen.

candid Celebrating 20 years

20 years and still the world's most *preferred* anti-fungal

(That does speak for itself doesn't it)

candid



Broad Spectrum • No Fungal Resistance • Excellent Tolerance

Based on quality. Built on trust.

For more information write to :
B/2 Mahalaxmi Chambers, 22 Bhulabhai Desai Road, Bombay 400 026. (INDIA)

Discussion

The incidence of the non infectious dermatoses almost approximates that of infectious dermatoses in the Kashmir Valley. On comparing our data with other regional studies we found that incidence of infective disorders amongst Kashmiris (50.6%) was slightly higher than that reported from Bombay,[2] Lucknow,[3] Jhansi[4] and Pune[5] but almost equal to that reported from Ladakh.[6] However, it was low (39.1%) in defence personnel. This variation is mainly because of better personal hygiene and socio-economic conditions among defence personnel than those civilians who attended skin and OPD.

Table I. Incidence of infective and non-infective dermatoses in civilians and defence personnel

Disease Group	Civilians		Service personnel	
	Number	Percentage	Number	Percentage
Infective	608	50.6	940	39.1
Non-Infective	592	49.4	1460	60.9
Total	1200	100.0	2400	100.0

The incidence of fungal infection in defence personnel was higher (10.5%) as compared to civil patients (6.3%) and this was probably because of prolonged wearing of closed footwear and uniform. Interestingly, there was significant variation in the incidence of herpes zoster and alopecia areata among two study groups. Psychological stress and strain of serving in area of militancy may be the precipitating factor for higher incidence of the said two dermatoses among defence personnel.

In our study the incidence of eczema was highest amongst non-infectious dermatoses both in civil as well as defence population. This is in accordance with almost all reports.[2-8]

Although there is no conclusive evidence for physiological acclimatization to environmental cold in man, Kashmiris certainly demonstrated super habituation and accustomization to severe winters. They had very little difficulty with hypothermia or frost bite. The hands very rarely become frozen, since when chilled they were held inside the woollen dress 'Phirans'. Undoubtedly native clothing played a large part in prevention of cold injury.

Table II. Skin diseases in Kashmir

Disease Group	Civilians		Service personnel	
	Number	Percentage	Number	Percentage
Bacterial Inf	126	10.5	64	2.6
Mycotic Inf	76	6.3	252	10.5
Viral Inf (Total)	168	14.0	436	18.1
Warts	32	2.6	232	9.6
Herpes Zoster	136	11.4	204	8.5
Ectoparasites (Total)	238	19.8	188	7.8
Scabies	222	18.5	112	4.6
Insect Bites	16	1.3	76	3.1
Dermatitis/Eczema (Total)	208	17.3	400	16.6
Eczema, unclassified	84	7.0	52	2.1
Pityriasis alba	08	0.6	12	0.5
Neurodermatitis	08	0.6	12	0.5
Seborrheic	16	1.3	28	1.1
Contact	60	5.0	196	8.1
Actinic	32	2.6	108	4.5
Acne /Rosacea	74	6.1	68	2.8
Psoriasis	54	4.5	108	4.5
Pigmentary Disease (Total)	28	2.3	128	5.3
Melasma	20	1.6	24	1.0
Vitiligo	08	0.6	104	4.3
Alopecia Areata	24	2.0	260	10.8
Congenital Disease	16	1.3	24	1.0
Cold Injury	18	1.5	172	7.1
Miscellaneous	170	14.1	300	12.5
Total	1200	100.0	2400	100.0

The greater awareness, better health education and ready availability of dermatology services for Armed Forces personnel is probably responsible for higher incidence of pigmentary disorders and alopecia as compared to local inhabitants. The incidence of other dermatoses in

non-infective group among Kashmiris and defence personnel did not differ much.

Finally, 'xerosis of the elements', as described by Failmezger[9] for dry, erythematous, hyperpigmented scaly lesions over exposed areas was a common feature in Kashmiris particularly among the children. The dry, cold winds and harsh sunlight of the valley climate are precipitating factors.

Acknowledgement

Authors thank No 6381216 'H' Hav/Clk Vs Chauhan for typing the manuscript.

References

1. Rook A, Savin JA, Wilkinson DS. The prevalence, incidence and ecology of diseases of skin. In : Rook A, Wilkinson DS, Ebling FJG, Champion RH. Burton JL, editors. Textbook of Dermatology, Bombay : Oxford University Press, 1987: 39 - 53.

2. Mehta TK. Pattern of skin disease in India. Ind J Dermatol Venereol 1962; 28: 134-139.

3. Gupta RN, Jain VC, Chandra R. Study of sociomorbid pattern at the skin out patient department of a teaching hospital in summer and winter season. Ind J Dermatol Venereol 1968; 34: 241-244.

4. Dayal SG, Gupta GP. A cross section of skin diseases in Bundelkhand region, UP. Ind J Dermatol Venereol Leprol 1977; 43: 258-261.

5. Sayal SK, Das Al, Gupta CM. Pattern of skin disease among civil population and armed forces personnel at Pune. Ind J Dermatol Venereol Leprol 1997; 63: 29-32.

6. Jaiswal AK. Pattern of skin diseases in Leh Ladakh region of India. Int J Dermatol 1994; 33 : 674-675.

7. Gangadharan C, Joseph A, Sarojini A. Pattern of skin diseases in Kerala. Ind J Dermatol Venereol Leprol 1976; 42: 49.

8. Behl PN, Mohanty KC, Banergee S. Ecological study of skin diseases in Delhi area. Ind J Dermatol Venereol Leprol 1979; 45: 260-264.

9. Failmezger C. Incidence of skin disease in Cuzco, Peru. Int J Dermatol 1992; 31 : 560 - 561.