DERMATOLOGY IN GENERAL PRACTICE*

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Individuals and their skins differ very considerably in their reaction to varying conditions, both physical and emotional. One skin will blush without apparent reason while another may fail to change colour even though accepted convention may demand that it should. Both the skin and conjunctivae of the redhead may react violently to either physical or emotional stimulation while a brunette may react more violently but give no dermal indication of either her actions or reactions.

Individual skins also differ in their response to physical and emotional trauma, parasitic, bacterial or fungal invasion, and internal and external assaults from what our friends the trade representatives call 'ethical preparations'.

Every disease must have a cause, but in no other group of diseases is relationship between cause and effect more variable and more dependent on individual susceptibility than in skin diseases. In no other diseases is it more essential that the doctor should know the patient. The patient is always more important than his disease.

It is the duty of the general practitioner to know and understand his patient and he cannot do this unless he has been suitably trained. He cannot be suitably trained by teachers who have no knowledge of general practice and no experience outside the artificial environment of the Teaching Hospital. It has always been, and still is, most unfortunate that medical students learn more about rare neurological lesions than about pruritus, acne and other common ailments.

The practice of medicine has always been, and should always be, an art, but an art based on sound scientific knowledge and scientific principles. It is essential that it remain such. Dermatology has now become a science, even if not always an exact science. Since penicillin has divorced dermatology from the ancient and once remunerative art of venereology it has become a popular speciality both with the doctor and the patient. But even with its newly acquired status, dermatology has not very materially changed either the classification or the prognosis in skin diseases.

Many years ago, skin diseases could be divided into two main categories: syphilitic and non-syphilitic. The non-syphilitic were occasionally classed and treated as syphilis because when in doubt the clinician was right and the laboratory was wrong. The non-syphilitic dermatoses were either acute or chronic and either parasitic, infective or of uncertain origin. Modern research has not changed our views on the aetiology of many of the conditions in this last category. Psoriasis serves as a good example. Treatment and prognosis have not changed. It is true that chrysarobin is no longer fashionable—Dithranol is used in its place, but the results are the same. Fifty years ago arsenic was prescribed for skin diseases of doubtful or unknown origin. It is still prescribed and when everything else fails mercury is also used. As all chronic skin diseases have occasional remissions, usually associated with changes in mood of the sufferer, there can be no doubt that both arsenic and mercury have at times been prescribed at the correct time and have been given credit where no credit was due.

It is not necessary that the general practitioner should be able to diagnose every skin condition. This can only be done by some dermatologists and by some skin pathologists. The general practitioner must be aware of his limitations. But it is essential that he should have a sound knowledge of all the commoner skin diseases and that he should know what not to do.

When a skin disease is difficult to diagnose the wise general practitioner will refer the case to a dermatologist without delay. The dermatologist, of course, may also have difficulty about the diagnosis, but he will not be blamed if the condition proves to be chronic; the specialist is never blamed, but the general practitioner will not be forgiven should he not have referred the case early. The country practitioner cannot always send the patient to a specialist, but he can always, if in doubt, do a skin biopsy and send the specimen to an expert skin pathologist. There are many conditions which can only be diagnosed correctly with the microscope. If possible, a good colour photograph should also be sent and, of course, a good clinical history is essential.

Conditions such as lupus erythematosus, though commoner than generally thought, are not diagnosed every day. Unless the general practitioner has had special training in dermatology he should not assume responsibility for the treatment of such conditions. He will get very little thanks and will get a great deal of blame.

Infantile Eczema

Infantile eczemas are very common and are the cause of many headaches, both for the doctor and the parents. It is essential that the general practitioner should know what not to do in these cases.

The eczema is not cured by changing the baby's food every time the napkins are changed. The skin condition is also not materially benefited by ointments, pastes and lotions. Infantile eczema is, in most cases, a psychosomatic manifestation indicating that the infant feels insecure in a very unstable world. This sense of insecurity is often the result of paternal rejection, maternal engulfment, or stupid interference by one or both mothers-in-law. Phenobarbitone should in no circumstances be given to the child, for it may lead to future barbiturate sensitization, but it can with advantage be given to the parents. The prescribing of tranquillizers for the mother, and in some cases also for the father, has often in my experience cured an obstinate infantile eczema. A notice prominently displayed in the nursery stating in both official languages that babies are not to be shaken may perhaps also do some good. Eczema can be caused by food allergy but this, in my experience, is not the most common cause.

Drug Allergies

There is great competition between the manufacturers of antibiotics and chemotherapeutic drugs and we are told

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of new drugs almost every day. Many of these drugs are new in name and some in formula, but they often have a molecular resemblance to other drugs previously employed. The patient who has become allergic to one drug may also be sensitive to chemically similar preparations. It cannot be pointed out too frequently that substances likely to cause sensitization should never be used on the skin and should also not be used in minor conditions where their use is entirely unnecessary. Penicillin and sulphonamides should under no circumstances be used as ear drops, nose drops, lozenges and other sensitizing media. Other antibiotics should also not be used in this way. The only substances of this nature which are safe on the skin are antibiotics such as bacitracin and neomycin which are too dangerous to be given by mouth or by injection.

Most minor ailments get well if the natural defence mechanism is not interfered with. Unnecessary prescribing of chemotherapeutic and antibiotic substances interferes with the natural defence mechanism and also renders many families of micro-organisms immune to the substances employed. Antibiotics which are more or less selective in their action may also destroy organisms which serve a useful function in keeping other and less desirable organisms in check. The indiscriminate use of antibiotics is rapidly producing immune strains of virulent organisms, particularly staphylococci, and is also producing a sensitized allergic population.

Penicillin-sensitive patients, sulphonamide and barbiturate reactors, streptomycin sensitives, tetracycline reactors, when added to salicylate, iodide and even antihistaminic-sensitive humanity, form a considerable percentage of the patients who seek our advice. Drug reactions and drug allergies may be difficult to diagnose on account of the wide variation in the appearance of the affected skin. There is no known skin disease which cannot be simulated by a drug reaction. Correct diagnosis is impossible unless the doctor has the time and the patience to obtain a reliable history.

Treatment is sometimes difficult and prolonged. All external applications are good, provided they can be relied upon to be inert. Calamine lotion is always safe and has the added advantage of not being an excessive drain on the patient's pocket. A saline dressing is sometimes very useful and an inert powder may relieve the symptoms. Antihistaminics given internally have a sedative action and are therefore useful. Applied externally they are either useless or harmful. In severe cases it may be essential to use ACTH or corticosteroids. The response is occasionally, but not universally, dramatic.

Contact Dermatitis

Modern man, particularly when employed in industry, is not always well adjusted to his industrial environment. The ability of the skin to adapt itself to the many substances with which it comes in contact largely reflects the ability of the owner to make a physical as well as emotional adjustment to his circumstances. Failure to adapt causes psychoneurosis and predisposes to contact dermatitis.

There is no industrial chemical, no oil, no paint or dye, no cosmetic, no ointment and no ointment base which will not at some time cause contact dermatitis. When this dermatitis involves the hands and is caused by some substance with which the sufferer must come in contact as a result of his employment, barrier creams may be useful, but they are not the answer to the adjustment problem. Antihistaminics are useless. Hydrocortisone and other corticosteroid-containing ointments will often suppress but will not cure the condition.

Many patients, particularly housewives, become sensitive to soap. Substituting a preparation such as Phisoderm for soap will sometimes cure the condition. Dermatitis of the face and neck is often cured when the redhead or blonde gradually resumes her natural colouring.

Ringworm

Ringworm of the skin is not very serious and presents no diagnostic problems. Treatment with weak tincture of iodine, with carbol-fuchsin or with phenyl mercuric nitrate is satisfactory. Irrespective of the method of treatment employed it must be discontinued after 4, or at the most 5 days. If the treatment is not discontinued a very unpleasant dermatitis may develop.

Ringworm of the scalp is sometimes very resistant. When the simpler forms of treatment do not cure the condition I refer these cases to the dermatologist or radiologist for X-ray epilation.

Epidermophytosis is still very common. The results of over-treatment are always worse than the disease. Foot powders containing undecylenic acid are probably the most satisfactory form of treatment.

Light Sensitivity

Many eczematous conditions of the hands and face are caused by sensitization to sunlight. Sulphonamides make the skin more photosensitive and should never be prescribed to light-sensitive patients. Chloroquin (Aralen) may be prescribed in these cases and often reduces the sensitivity to light. Mepacrine is equally good, but stains the skin if given for prolonged periods.

Pyodermas

About 12 years ago sulphonamide ointments and penicillin ointments heralded a great advance in the treatment of bacterial infections of the skin. They are no longer used on account of the very high incidence of severe sensitization reactions. The most suitable ointments for use in these conditions contain neomycin, bacitracin and polymyxin. Tetracyclines and erythromycin are also very useful in ointment form, but are best avoided. These broad-spectrum antibiotics are best given by mouth. Parenteral penicillin is not always contra-indicated in these cases, but should be avoided if possible.

Pruritus

Pruritus, particularly pruritus ani, is a most distressing and embarrassing condition. It is very common after the prolonged use of broad-spectrum antibiotics, when it is caused by a monilial infection. Vitamin-B complex should always be prescribed when tetracyclines are administered for a long period. Mycostatin usually cures the monilial infection. Every case of pruritus requires most careful investigation. Blood dyscrasias, renal disease, diabetes and subclinical jaundice can all cause severe itching. Many cases of pruritus are psychogenic in origin and tranquillizing drugs are very useful in these cases. When the population has become sensitized to the presently popular tranquillizers their use will also be contra-indicated.

Acne

Acne is the commonest of all skin diseases. It is a disease of adolescence and is associated with excessive production of androgens in relation to oestrogens. It is related to the physiological transition of the skin to the adult stage, and is occasionally associated with emotional maladjustment. Hot water and liquid soap followed by the use of a sulphur lotion is good treatment. Small doses of oestrogens can safely be given to both sexes. In some cases small doses of thyroid are useful. Unless acne is treated early, permanent scarring may result and this, particularly in the case of young girls, sometimes has unfortunate psychological consequences.

Sufferers from acne must have sufficient exercise, sufficient recreation and suitable social interests. They must be assured that acne can be cured. Suitable friendships with members of the opposite sex are more effective than pills and lotions.

It is essential that young people have a suitable diet. Protein and vitamin intake must be sufficient and the consumption of fat and carbohydrate can with advantage be reduced, but diet will not cause or cure acne.

The general practitioner must know and understand his patients. He must be guide, philosopher and friend, know their secrets, share their joys and understand their problems. This is his duty and his privilege. Having the confidence of his patients, the family doctor can solve problems in personal relationships. He can assist in removing tensions and anxieties which play such an important part in the aetiology of skin diseases.