

## CHAPTER 1

# Introduction and Historical Bibliography

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### What is dermatology?

Dermatology is defined in The New Oxford Dictionary of English as 'The branch of medicine concerned with the diagnosis and treatment of skin disorders' [1]. However, dermatologists do not confine themselves merely to a study of intrinsic disorders of the skin, but must also study internal medicine and the many environmental and occupational factors that so frequently cause skin problems.

A plethora of external factors, including numerous chemicals, can adversely affect the skin in some circumstances. The clinical dermatologist must be knowledgeable about these potential hazards, and this will often require a detailed study of the multiplicity of chemicals, plants, animals, parasites, microorganisms, radiation, climatic conditions, etc. to which the skin is exposed. In many cases, the dermatologist will need to obtain exact details of what is involved in the patient's occupation and hobbies, and many dermatologists build up a considerable knowledge of the different jobs involved in their local industries.

The dermatologist must also have a good knowledge of internal medicine, as most systemic diseases can occasionally affect the skin, either directly or as a result of a complication of the disease or its treatment. Drugs taken by the patient have to be considered by the dermatologist, because the unwanted effects of many drugs include provocation of rashes. This applies not only to prescribed medication, but also to over-the-counter and complementary/alternative remedies. The use of complementary medicine is increasing in the Western world, and many individuals with dermatological problems use such remedies [2–4], their availability having been made easier by the advent of the Internet [5].

A dermatologist must also pay attention to the psyche, as psychological factors play an important part in dermatology. The skin is of major importance in our 'body image', and the fact that skin diseases are often regarded with revulsion by the general population adds to the distress they cause, so that the psychological disturbance induced by skin problems may be out of all proportion to their 'medical' significance. Sometimes, these psychological

problems are exacerbated by the reactions of the patient's relatives, friends or colleagues, and in other cases they are partly accounted for by feelings of guilt or despondency, induced by the belief that skin diseases are due to 'uncleanliness' of some kind (with or without sexual overtones). In recent years there has been increasing awareness of the impact of skin diseases on social and leisure activities, work and sexual relationships, and questionnaires such as the Dermatology Life Quality Index (DLQI) have been employed to measure the impairment of quality of life (see Chapter 72). Not only may skin diseases cause stress or depression, but also psychological stress from another cause can exacerbate, or even be involved in causation of, some skin diseases.

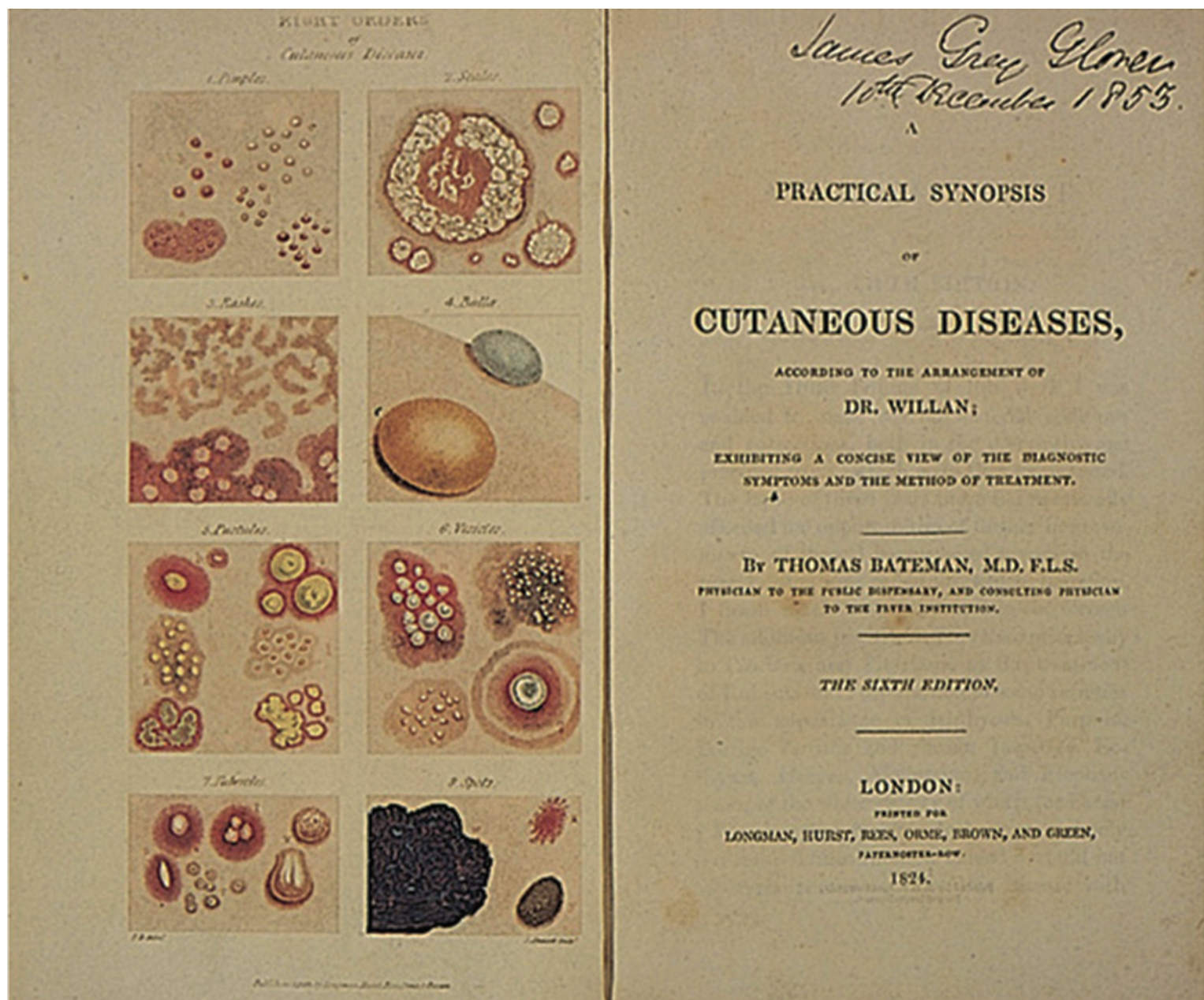
Whatever the complexity of these psychological nuances, the dermatologist must be aware of their existence and try to deal with them accordingly. As described later (Chapter 64), some patients have 'skin problems' that are imagined or self-inflicted, and the presentation to the dermatologist seems to be a 'cry for help' with marital or other social problems. In other cases, the dermatological consultation may be a manifestation of an underlying psychological disorder such as depression or schizophrenia.

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- 3 Berk DR, Kanzler MH. Prevalence of alternative medicine use for skin conditions in a primary care population. *Arch Dermatol* 2004; **140**: 892.
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- 5 Affleck A, Varma S. A case of DIY Mohs surgery using bloodroot obtained from the internet. *Br J Dermatol* 2007; **157** (Suppl. 1): 111–2.

### The evolution of dermatology

Skin diseases predate written records, and many of the earliest medical writings deal with dermatological subjects. The history of dermatology is too large a subject to be covered in this book, although a selected historical bibliography is given at the end of this chapter. The development of modern dermatology is briefly outlined below.

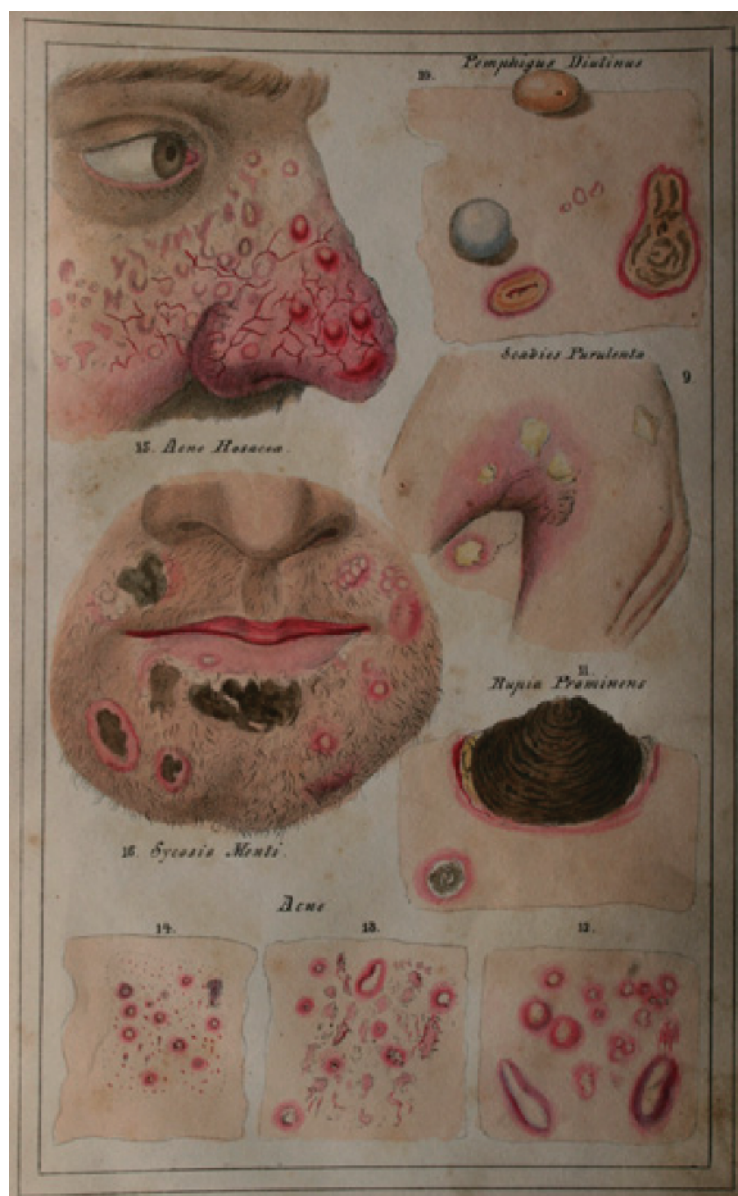


**Fig. 1.1** The title page and facing plate from the 6th edition (1824) of Thomas Bateman's *A Practical Synopsis of Cutaneous Diseases, According to the Arrangement of Dr Willan*. The plate shows the eight orders of cutaneous eruption in Willan's classification.

Dermatology evolved as a branch of internal medicine during the 19th century. Previously, many diseases of the skin had fallen within the province of the quack or the surgeon, and indeed many of the older surgical textbooks devote much attention to the treatment of skin disease. The physicians of that time were little concerned with the skin, apart from the eruptions of the acute infectious fevers. In the early 18th century, individuals such as Daniel Turner advocated use of preparations applied to the skin as treatment for internal diseases. During the last decades of the 18th century, however, many of the great physicians began to record their observations on the diseases of the skin, and this continued throughout the 19th century. Towards the end of that century, skin diseases, particularly the chronic infections such as

syphilis and tuberculosis, formed a significant part of the general physician's practice, and by the early 20th century some physicians were beginning to specialize in dermatology. This trend towards increasing specialization has continued ever since.

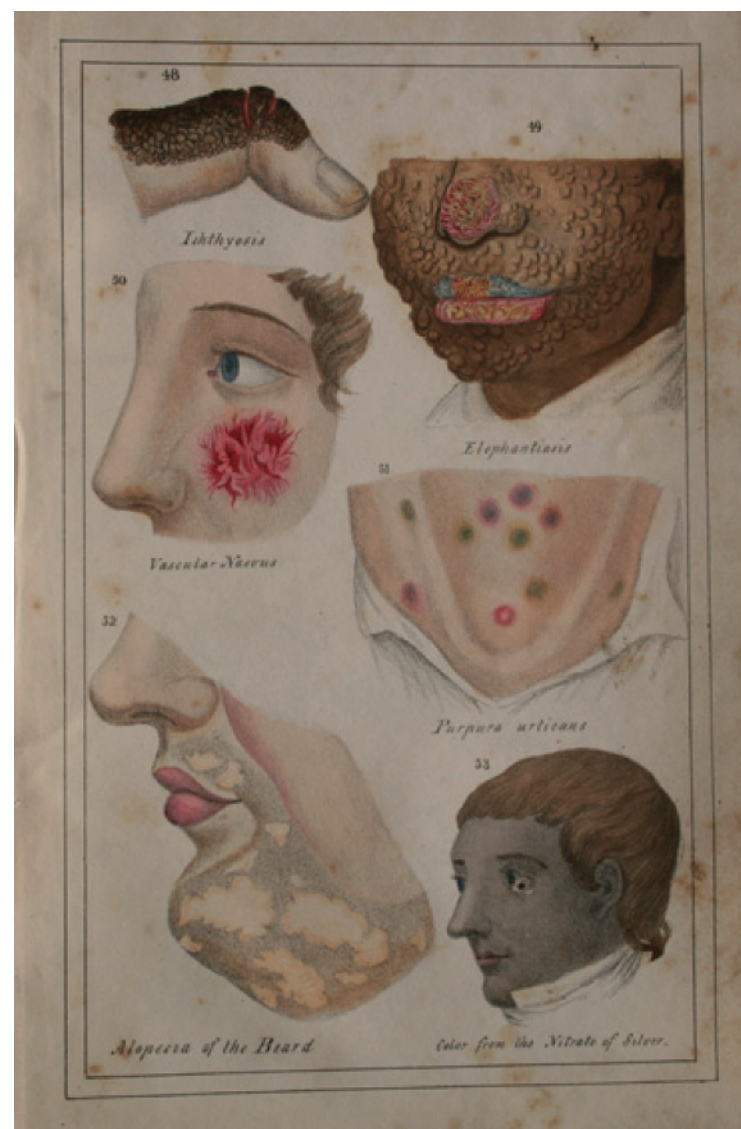
In the first half of the 20th century, dermatology was slow to develop along scientific lines. The emphasis was very much on the clinical description, naming and classification of the numerous skin disorders, and this led to a profusion of synonyms which are daunting to those attempting to get to grips with dermatological nomenclature. Only empirical treatment was available, and it was often ineffective, messy and malodorous. Dermatology certainly lagged behind some of the other medical specialties in its understanding of basic disease processes. In retrospect, this seems to



**Fig. 1.2** A variety of mainly pustular disorders, from N Worcester, *A Synopsis of the Symptoms, Diagnosis and Treatment of the More Common and Important Diseases of the Skin* (1845).

have been due to two main factors. The first was that most skin diseases could be identified by external examination alone, and therefore seemed to need no further investigation. The second, and perhaps more important factor, was that most skin diseases could not be investigated by the relatively crude tests that were available at that time. It was only when skin biopsy became a standard technique, with the plethora of pathological knowledge that followed, that an understanding of the pathogenesis of many skin diseases began to emerge.

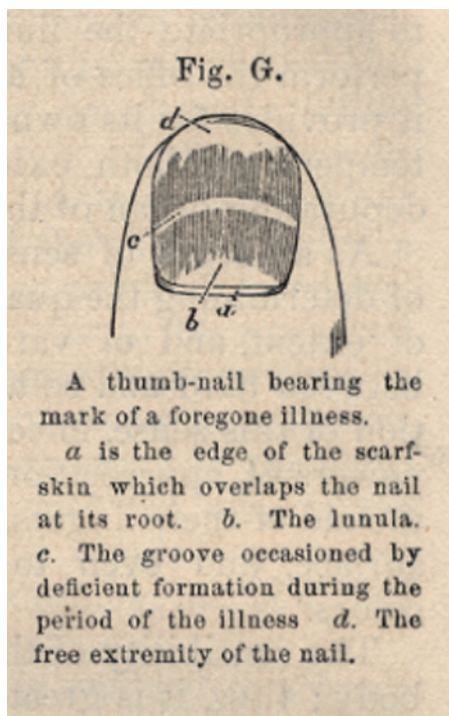
In the second half of the 20th century, there was an explosion of dermatological knowledge, mainly as a result of the introduction of sophisticated research techniques which not only led to a better knowledge of the pathogenesis and treatment of skin disorders, but also facilitated the development of more targeted treatments.



**Fig. 1.3** Illustrations from N Worcester, *A Synopsis of the Symptoms, Diagnosis and Treatment of the More Common and Important Diseases of the Skin* (1845), including a dramatic illustration of argyria (made more startling by the shift in position of the blue colouring of the pupil of the eye).

The need for measurement and a more scientific approach in dermatology was made over 40 years ago [1], and research, at least during training, became the norm for generations of dermatologists. Advances in pathology techniques, especially immunopathology, helped the understanding of skin disease. More recently, the techniques of molecular biology have also been applied (Chapter 11), leading to, amongst other things, important developments in genetics and the understanding of mechanisms underlying cancer. As a result, increasing numbers of non-medical scientists are studying the skin, and its accessibility, which paradoxically inhibited investigation in the first half of the 20th century, is now of course very helpful to the research worker.

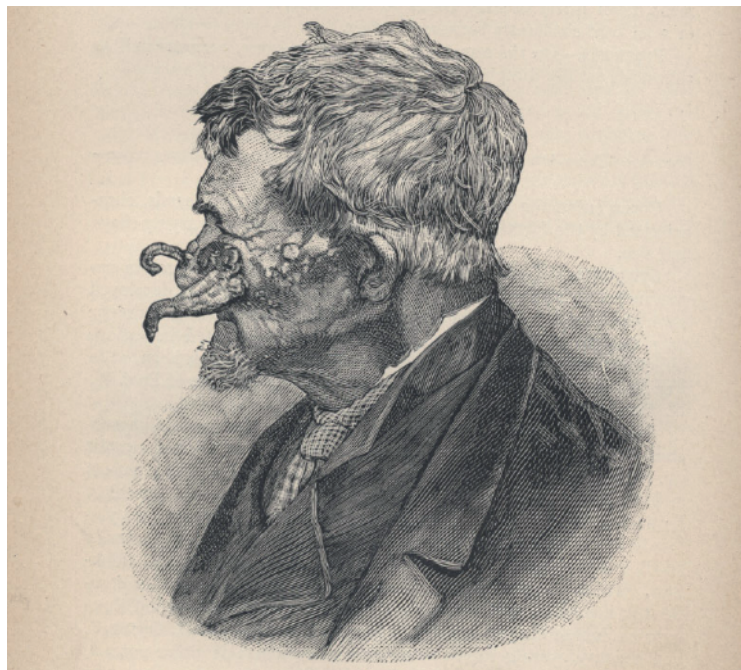
Dermatological treatment patterns have changed over the last 50 years, and will no doubt continue to do so. Recent advances in treatment include topical immunosuppressants, immune response modifiers, enzyme replacement treatments (e.g. for



**Fig. 1.4** An early picture of a Beau's line, from the section on nail growth in Erasmus Wilson's *Diseases of the Skin; a System of Cutaneous Medicine*. This is from the 1868 revised 6th edition. Erasmus Wilson also published major works on anatomy.



**Fig. 1.6** Infantile eczema. From: JV Shoemaker, *A Practical Treatise on Diseases of the Skin* (1890).



**Fig. 1.5** Cutaneous horns. From: JV Shoemaker, *A Practical Treatise on Diseases of the Skin* (1890).

Fabry's disease) and biological therapies for psoriasis and other dermatoses. Further sophistication in treatment should parallel increasing knowledge of the roles of inflammatory mediators in disease, and gene therapy is on the horizon. Some older treatment modalities, such as radiotherapy, are used much less, but are still

of considerable value in selected cases (Chapter 79) and have even increased in use for some conditions such as lentigo maligna.

Dermatology is thus changing at an ever-accelerating pace, both in the amount of scientific knowledge and treatments available, and with regard to disease patterns and patients' expectations. Increasing specialization within dermatology is becoming more common, with the expansion of expertise in dermatological surgery, laser therapy, photobiology, contact allergy, histopathology, and other areas; some dermatologists now only work in subspecialty areas such as paediatric dermatology, skin surgery, etc. Certainly, dermatologists can no longer be regarded only as general physicians with an interest in the skin, although some training in internal medicine is still regarded as desirable in most countries. In the UK, trainee dermatologists are expected to have completed a minimum of 2 years of general professional training and to have passed a postgraduate examination in general medicine (Membership of the Royal College of Physicians, MRCP) before they can start their specialist training in dermatology. The specialist training entails 4 years in an approved training post, with an annual assessment of progress, on satisfactory completion of which the trainee is awarded a Certificate of Completion of Training (CCT).

It seems possible that the days of the generalist dermatologist are numbered. Future dermatologists will perhaps regard themselves as dermatological physicians, surgeons or researchers and train accordingly. The future cannot be predicted, but it seems certain that with the increasing sophistication of populations throughout the world, the demand for dermatological expertise is likely to increase.



**Fig. 1.7** Discoid lupus erythematosus, from Henry Radcliffe Crocker's *Atlas of Diseases of the Skin* (1896). Radcliffe Crocker made many contributions to dermatology; this atlas was available in an unbound form, apparently so that the colour plates could be used for teaching.

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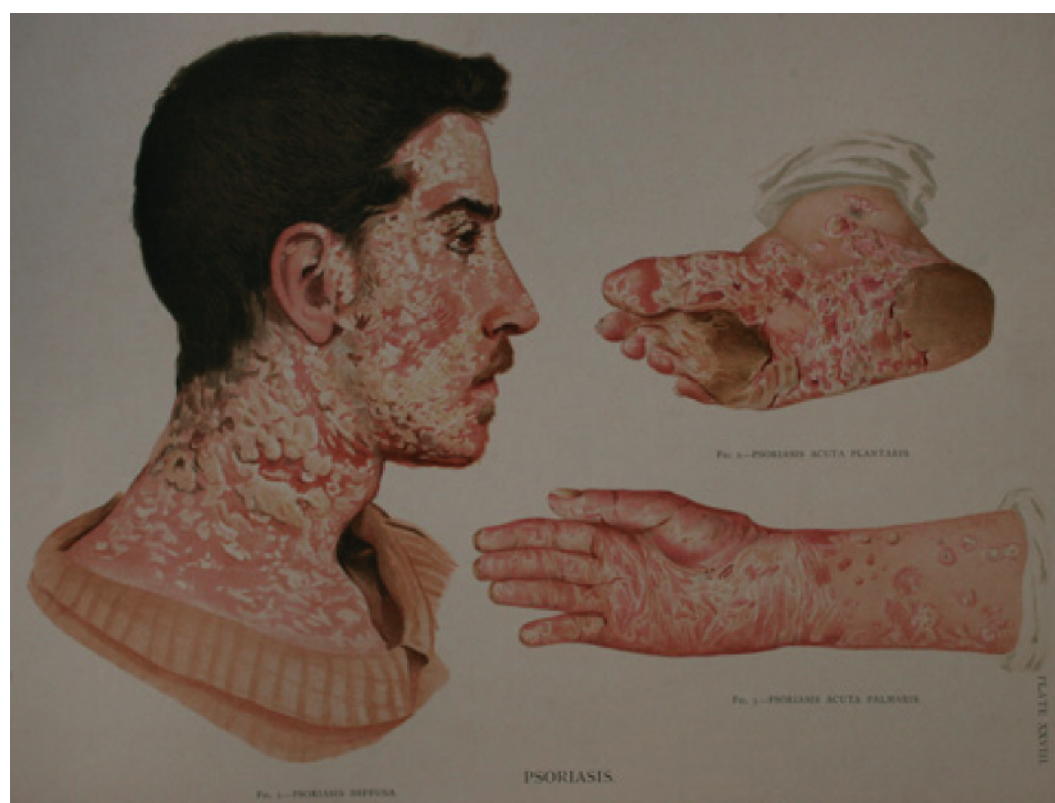
### The dermatologist's work

There are probably at least 2000 different skin conditions that might present to the dermatologist, and the conditions seen vary enormously in severity. They range from cosmetic problems, such as dry skin or wrinkles, through a huge variety of acute or chronic diseases, which may be disfiguring, itchy or painful, but are rarely fatal, to life-threatening conditions, which, if untreated, may prove fatal within days (e.g. toxic epidermal necrolysis), weeks (e.g. pemphigus), months (e.g. malignant melanoma) or years (e.g. mycosis fungoides). In the UK, about 70% of consultations for dermatological problems are related to skin cancer, acne, psoriasis, viral warts and other infections, benign tumours, leg ulcers, and various forms of dermatitis [1]. In an audit of dermatology services in Edinburgh, UK, in November 2005, management of patients with eczema and psoriasis accounted for one-third of outpatient clinic visits. It was notable that, compared with data from 1980, attendances for both benign and malignant skin tumours had increased six-fold [2].

Obviously, the pattern of disease varies from one country to another, and even in the same city the work of dermatologists will differ, depending on their particular interests and expertise and on the social mix of their patients. Involvement with cosmetic procedures, in particular, varies according to the constraints of the health-care system in which the dermatologist works.



**Fig. 1.8** Sarcoma cutis, from Radcliffe Crocker, *Atlas of Diseases of the Skin* (1896). The reasons behind wide excision of melanoma are readily apparent.



**Fig. 1.9** Psoriasis, from Radcliffe Crocker, *Atlas of Diseases of the Skin* (1896); the illustration is as valid now as it was then.

Space precludes any detailed consideration of the work of dermatologists throughout the world, but in the British system patients are normally first seen by a primary-care physician (general practitioner [GP]) who refers the patient to the hospital consultant if he or she thinks it necessary or advisable (secondary care). It has been estimated that around one in seven primary care consultations relates to a dermatological problem [3,4]. Hospital dermatology services are provided by consultant dermatologists and their supporting staff. The British Association of Dermatologists provides guidelines for provision of services in secondary care [5], and the current working target with regard to consultant dermatologists is 1/100 000 population (assuming that there is provision of some supporting medical staff and nursing expertise), although in parts of the UK this is not achieved. There is government pressure in the UK for some dermatology services to be provided in smaller community settings [6], rather than in secondary-care hospitals. A more seamless 'Integrated service' has been proposed, with dermatologists having a greater role in teaching, care of complex patients, and administration of this new model of care [7]. This system would involve more non-medical practitioners such as expert nurses and pharmacists, but the mainstay of the intermediate level of care is likely to be provided by GPs, who have undertaken additional training in dermatology and work as a team, performing some independent clinics and some clinics with consultant staff. Subsequent research has shown potential advantages of this intermediate grade (termed GP with a Special Interest, GPwSI) in provision of local services for patients, but there is also some unease about the relatively small amount of training that some such individuals undertake and some aspects

of care have been documented as less safe or more expensive [8,9].

In the USA, the dermatologist-to-population ratio increased from 1.9 per 100 000 in 1970 to 3.5 per 100 000 in 2002 [10], although there is considerable interstate and intrastate variation in this ratio [11]. There are, of course, some countries from which dermatologists are conspicuously absent.

There is continuing concern about provision of an adequate number of trained dermatologists to satisfy increasing demand, and that an increase in the number of dermatologists specializing in surgical and cosmetic procedures might lead to a shortage of those dealing with 'medical' dermatology patients [10–16]. It is also important that planning should take account of factors such as age [17], the high proportion of women in dermatology and the changing roles of nursing staff [18].

Many skin diseases, for example warts, acne vulgaris or psoriasis, can be quickly diagnosed by their clinical features, and need little or no further investigation. At the other extreme, there are some patients, for example those with lymphoma, who need detailed and time-consuming investigations both to confirm the diagnosis and as a basis for treatment.

The most common investigations performed in a dermatology clinic, other than simple blood tests or swabs for microbiology, are skin biopsies. Other investigations include the extraction and identification of scabies mites, the microscopic examination of hairs, microscopy for fungal mycelia or spores, patch testing and photopatch testing. In occasional cases, special procedures may be needed, such as the examination of pets for animal parasites, or a visit to the patient's workplace or home to search for possible allergens.



Fig. 1.10 Structure of the skin, from WS Gottheil, *Skin Diseases* (1897).

The management of this infinite variety of skin disorders ranges from simple reassurance and explanation through the gamut of topical and systemic remedies, to the performance or supervision of numerous physical procedures such as UV irradiation, photochemotherapy, curettage and cauterization, surgical excision and laser treatment. Some dermatologists will also undertake complicated and specialized techniques such as prenatal investigation and Mohs micrographic surgery, which may require close collaboration with other specialists, and newer techniques such as photodynamic therapy are finding a niche in the dermatologist's armamentarium.

Greater patient expectations and a generally more litigious attitude in society have combined in recent years to fuel physicians' concern about being sued, and the increasing complexity of dermatological practice and involvement in cosmetic procedures may heighten the risk. Thankfully, however, litigation is still relatively infrequent in dermatology compared with other specialties [19–21]. Evidence-based guidelines have been produced for many dermatological conditions, both in the UK [22] and in many other countries [23,24], and are probably helpful in encouraging good practice (although evidence that they fundamentally alter practice is lacking); manufacturers of some drugs used in dermatology produce quite rigid guidance (for example, for administration of



Fig. 1.11 Scabies, from RW Taylor, *A Clinical Atlas of Venereal and Skin Diseases* (1889).



Fig. 1.12 Impetigo contagiosa, from the *Portfolio of Dermochromes* by Professor Jacobi (1903). The English adaptation of the text was performed by JJ Pringle of the Middlesex Hospital. The majority of the illustrations were of models in the Breslau Clinic.

isotretinoin in females), and dermatologists in the UK are also subject to various government directives, such as those from the National Patient Safety Agency and the National Institute of Health and Clinical Excellence. These may apply to uses of certain medications (e.g. prescribing of methotrexate, or of specific biological agents,

for psoriasis) or may cover a broader remit, such as guidelines for management of skin cancer [25].

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