Guest editorial

Community dermatology

G Todd, BSc (Agric), MB ChB, FFDerm (SA), PhD

Emeritus Professor, Department of Medicine, University of Cape Town, South Africa, and Vice-President, International Society of Dermatology, 2013 - 2017

Corresponding author: *G Todd (gail.todd@uct.ac.za)*

The skin is an amazing feat of engineering, designed to operate as an air-liquid interface. It is the largest organ in the body, and has many functions essential for life. Without a skin one cannot survive, as is evident in burn victims, those with severe blistering disorder of the skin, and those with extensive skin disease who are vulnerable to skin failure.

One only gets one skin. It cannot be transplantated, as can many other body organs. It needs to be protected and treated once skin failure occurs.

The skin is an interface between our bodies and the outside world. It protects us from external hazards such as infections, and physical agents such as UV light, heat, cold, trauma, pressure and friction, while providing essential metabolic functions such as vitamin D production, temperature regulation, haemodynamic homoeostasis, and excretion. The eccrine sweat gland's function is similar to that of a kidney glomerulus and tubule, responding to the same hormonal stimuli.

While most skin diseases do not directly lead to death, there have been more fatalities based on discriminatory skin features such as skin colour than specific organ disease. Because administrators concentrate on the burden of disease linked to mortality rates, people with skin disease are marginalised and suffer ongoing discrimination because of visible disfigurement. Ironically, a dysfunctional skin can lead to dysfunction of other systems such as cardiac decomposition caused by haemodynamic instability, cardiac and renal failure due to skin infections caused by streptococci, bone disease due to vitamin D deficiency, and neuropsychiatric dysfunction such as depression and even suicide. More recently, chronic inflammation contributing to atherosclerotic disease has been recognised as being associated with severe psoriasis and metabolic syndrome. Defects in the amazing barrier function of the skin are now being investigated as the area of sensitisation that leads to atopy.

As an interface for communication, skin is central. It is the means by which we communicate with the outside world. It has a multitude of sensors without which one would injure oneself, such as in leprosy, peripheral neuropathies and diabetes. The same sensors also supply the psyche with innumerable pleasurable inputs important throughout life, but especially in infancy and childhood. When deprived of these pleasurable inputs, i.e. close contact and touching, because of skin disease, psychosocial problems develop and poor self-esteem results with attendant consequences.

The 'look good, feel good' factor, another communication interface, has dominated current skincare, although it has been recognised for centuries as important for individual success and achieving one's potential. Unfortunately, it is also discriminating; those who do not conform to norms of physical beauty are marginalised. The media have had an enormous influence in this regard. Has a bad person ever been portrayed as the typical fashionable norm of beauty for any specific era? It is always those who look different, often because of skin disfigurement, who are cast as villains.

Current health policies reflect this prejudice, with many undergraduate training programmes internationally offering appalling training – often none at all – on the skin, its functions and the consequences of its failure. For the poor and vulnerable, this is further compounded by the lack of specialist skills in state services; therefore many with skin disease suffer daily discrimination at many levels.

This issue of *CME* is an attempt to showcase the efforts of a few dedicated doctors and nurses internationally who are trying to fill this immense void. The countries were chosen because they represent the geographical areas where the global burden and need are greatest. They use several different approaches that have involved NGOs and international bodies in co-operation with national governments, individual doctors, nurses, village healthcare workers, and patients and their families. It is hoped that their stories will encourage others to provide similar programmes where there is a need for a medical specialty. The most important factor to ensure sustainability of any such programme is the co-operation and buy-in from government, communities and those affected.

South Africa can be particularly proud of the contribution from two nurses who run services in the Western Cape. The nurse-led programme was a dream for 10 years before the short course for dermatology nursing was introduced in 1997, thanks to the collaboration between nursing and dermatology and the vision of a few dedicated people in the face of repeated rejection and refusal. The Free State and KwaZulu-Natal universities have recently been active in developing similar programmes for nurses. The only serious hurdle to overcome at this point is the slow pace of the South African Nursing Council in recognising new specialties for nurses despite the urgent need for dermatology care. Today this model is being applied worldwide, and it is hoped that the fledgling programmes currently struggling to survive in South Africa will not be allowed to fail because of historical prejudice and financial issues.