The Inaugural Sri Lanka Association of Dermatologists Oration

A 32 year journey in dermatology

D N Atukorala[1]

Sri Lanka Journal of Dermatology, 2001, **5**, 12-21

Dr.T T Kasturiratna, President of the Sri Lanka Association of Dermatologists (SLAD), our chief guest for this year, Dr. Vijaya Bahadur Rajbandhari, President - South Asian Regional Association of Dermatologists, past presidents and members of the committee of the SLAD, ladies and gentlemen.

I am deeply conscious of the great honor in being invited to deliver the inaugural Sri Lanka Association of Dermatologists oration, particularly in this the millennium year. I sincerely thank the President and committee, particularly Dr's. WDH Perera, Prasad Kumarasingha, T T Kasturiratna and Ganga Sirimanna, who among others were chiefly instrumental in setting up the idea for this oration. To set down some of my thoughts and my work in a 32 year journey in Dermatology, would, I thought, be of little interest to many of you. I was then reminded that this would also reflect a 30-year slice of the recent history of the development of dermatology in Sri Lanka, the successes and the frustrations.

32 years ago when I was to begin my career in dermatology, as a house officer, I was delayed a full six weeks by my very eminent consultant surgeon at that time, who told me, "why on earth do you want to do dermatology? A discipline where no one dies and no one gets well". Attitudes have perceptibly changed now and dermatology is a popular postgraduate specialty. The last year when the board of study in dermatology of the Post Graduate Institute of Medicine, decided to inaugurate a special programme leading to an MD in dermatology, we decided to select 8 trainees for the training slots available. We were very gratified to find that 197 candidates had applied for this selection examination.

The journey started in 1968, in ward 56, the last ward in the then General Hospital, Colombo. We were sharing our ward with Cardiology, of all specialties. These were early days in dermatology in Sri Lanka. Dr Tissa Ratnaike, the Consultant Dermatologist, was only the 2nd recognized dermatologist in Sri Lanka. He was my "guru" and mentor in dermatology: a superb clinician, with a clear mastery of medicine and an eye for the detail. Above all he was a true gentleman. I remember clearly how the late Dr Gamimi Wijesekera, then the senior house officer in Cardiology, brought his illustrious father, to me, his fellow house officer, for management of a chronic urticaria problem. After two visits he still was having the annoying symptom of itching. For his luck, Dr Ratnaike was present in the ward at the next visit, and recognizing the eminent academician, examined him and discovered the layer of *Candida albicans* on the palate under his dentures – a lesson in the detail of history and examination that I never forgot.

I can remember dermatology in my student days, when we visited the dermatology ward only out of curiosity, after a few badly attended lectures on the subject. I can remember vividly the male patients in the ward, in loin clothes and ointment daubed all over and for good measure, painted red (magenta), blue (gention violet) and green (cresyl green) – I thought, like red Indians. It is to the credit of Dr. Ratnaike that he brought in the scientific basis for dermatology and restored patient dignity. My pet aversion to coloured paints on the skin, effective as they most certainly were, probably started from these experiences.

A few of the interests acquired at this stage remain to date. The interest in leprosy was fuelled by the then WHO consultant to the leprosy campaign, Dr Nosito, a man with a passionate devotion to leprosy and a superb knowledge of dermatology. Erythroderma following an infection of *Nocardia Asteroides* isolated from a bone marrow aspirate remains the only such case I have encountered, but the interest in erythroderma continues. We reported two cases of systemic sclerosis with "spotty pigmentation" and this disease and the particular sign continued to be one of my interests. Later in 1988, I reported 16 patients with systemic sclerosis of these 15 had the sign of speckeled leucoderma, especially on the retro auricular areas and the neck, and in 11 this was the presenting feature. This was a previously unrecognized feature[1]. Rare cases of clinical interest remain the forte of dermatologists and the case of Gorlin's syndrome (naevoid

[1] *Consultant Dermatologist (Formerly at the National Hospital of Sri Lanka) No. 7, Arethusa Lane, Colombo 6.*

basal cell carcinoma syndrome) remains in my mind. A patient of mine with Gorlins Syndrome was lost to follow up but I found him many years later peering at a shop window in Union Place, in Colombo and we both recognized each other. He had by this time lost an eye to a basal cell carcinoma and subsequent radiotherapy.

I started on my own in dermatology, in charge of a department, only in the capacity of acting dermatologist, in Jaffna in 1971. This was a most unexpected appointment. I had decided to speak to the then Director of Health, Prof. K. Rajasuriya, my Professor of Medicine and a person we all held in awe, in a state of great agitation over a scholarship that I had been awarded in another specialty, but finally been refused. Though aggressive at first, he quickly understood the situation and said that he could obviously do nothing about what had happened, but would try to accommodate me in any further interest. I found myself telling him then that my interest was now definitely dermatology. I had by this time completed 2 ½ years in dermatology. I can still remember him saying "Ah it's dermatology is it? Yes, You do dermatology in Jaffna". I later found that the dermatologist there had left the island suddenly. Jaffna was not what it is today – but still quite a distance from Colombo. Life's decisions are so often a matter of chance.

And so I arrived in Jaffna on the 3rd of April 1971, a day before the first insurrection in the south. Jaffna was peaceful and calm. It was with pride that I took over the daily clinic and ward sections allotted for dermatology. I remember with gratitude the medical superintendent, the consultants and the medical staff of the hospital all of whom went out of there way to make me feel comfortable and feel wanted in Jaffna. It was probably the friendliest atmosphere I have ever worked in. It was in Jaffna that I did the first study on the patterns of skin diseases in a skin clinic in Sri Lanka[2], and the patterns of skin diseases and their prevalence remained a continuing interest.

St. John's Hospital for Diseases of the Skin, London

It was after Jaffna, that I was sent to UK under a Commonwealth scholarship for postgraduate training. This was at St. John's Hospital for diseases of the skin, the Institute of Dermatology of the University of London, situated snugly between a sandwich shop and a social club in Leicester Square, in the heart of London.

Behind this extremely unassuming exterior is a compact but wonderful teaching hospital, with some of the best in dermatology and equipment. I learnt much for my future under eminent people, such Prof. Calnan, Prof. Wilson Jones and Prof. Ronnie Marks. It was here that I undertook some work on basic cutaneous biology, under the guidance of Prof R. Marks. We tried to determine whether mitotically dividing basal cells were uniformly distributed throughout the basal layer or were clustered, by using H3 labelled thymidine which would be taken up only by dividing cells. This was injected into the living hairless mice skin, harvested and the skin split at the dermoepidermal junction and the basal layer studied for thymidine uptake. The focal nature of the mitotic division (mitotic clustering) was established by studying the distribution of the cells with thymidine uptake. This work has been confirmed later by much more sophisticaed studies. It was also here that my interest in dermatohistpathology began under the influence of Prof. Wilson Jones at the regular histopathology sessions.

On my return to the country after postgraduate studies I was first posted to Galle, where a dermatology department had been set up and then abandoned. The beds given to dermatology in Galle in the then Hospital in Mahamodera, were the worst available, the last beds in wards, those nearest the toilets. The first satellite clinic in dermatology was set up at Matara, on a weekly basis during this period.

Events beyond my control transferred me temporally back to the General Hospital Colombo, and then to set up 2 new departments in Colombo South and Colombo North Hospitals, both now teaching departments for undergraduates and post graduates. In Colombo South I continued the tradition of satellite clinics and 3 such clinics were run once a week, at Avissawella, Homagma, and Panadura. Two of these are now permanent dermatology departments. It was in 1988 that I moved to the goal, the Mecca, General Hospital Colombo.

The development of dermatology as a specialty

When I started dermatology as a house officer there were only 3 dermatologists in the hospital sector, and about another 3 in private practice. The training to become a consultant dermatologist included working under a dermatologist for a varying period and obtaining the MRCP in the UK. No formal training was needed in dermatology. On our return to Sri Lanka we were considered consultants in Dermatology. With the establishment of the Postgraduate Institute of Medicine in 1979, dermatology came under the Board of Study in Medicine. The training for a dermatologist included obtaining the MD in Medicine and undergoing one year's training in dermatology in Sri Lanka, and

one year in a centre of excellence abroad. The other achievement was the inclusion of dermatology in the training programme of a general physician, on par with other major subspecialties of medicine.

Subsequently a separate board of study for dermatology was established in December 1994 mainly due to the efforts of Dr Keerthi Weerasekera and Dr.WDH. Perera. A curriculum with set aims, a definite programme of training and assessments during a 2-year training in a center in Sri Lanka was laid-down and carried out, after successful completion of the MD in Medicine[4]. In March 2000 the first set of trainees were selected by a highly competitive examination to undergo training and assessments in dermatology and medicine and to finally sit for the MD in Dermatology of the PGIM[5]. This programme is now being successfully carried out with 8 trainees.

The establishment of the Sri Lanka Association of Dermatologists in 1985, with Dr. Lakshman Ranasinghe as its first president, was another milestone. Our membership of the International League of Dermatology Association, 2 joint academic meetings and an exchange programme with the German Dermatologic Society, through the efforts of Dr. W D H Perera, our links with the Dowling Club and the British Association of Dermatologists through the efforts of Dr. Ganga Sirimanna, our links with the Mayo Clinic through the efforts of Dr. Prasad Kumarasinghe and now our links with our SAARC neighbours, have established us as an integral part of the world dermatology scene.

At a workshop held on the development of a prospective plan for health development in 1994, with the Ministry of Health, we were able to convince the Ministry as to the need to develop dermatology services, to establish dermatology departments in 60 hospitals of the country – a goal we are trying to achieve with our new training programme.

So the last 32 years have seen a tremendous advancement and recognition of dermatology as a specialty in Sri Lanka.

Patterns of skin diseases in hospital clinics and the prevalence of skin diseases in the community

It was in Jaffna that the first study of the patterns of skin diseases in a skin clinic in Sri Lanka was done[2]. Hospital clinic attendance patterns are only an approximate guide to the prevalence of skin diseases in the community, but these have been extensively used to compare disease patterns in different countries. Cutaneous infections formed a large group of diseases. Most series from developed countries show low figures for cutaneous infections, other than viral. Though a series from London in 1957[6] had very low percentages for fungal, bacterial and parasitic infections, a similar study in 1903[7], shows figures very similar to the Jaffna study[2]. This probably shows the effects of socio-economic conditions on the patterns of cutaneous infections. No malignant or premalignant lesions were seen in the Jaffna series as contrasted to the 4.5% from Wycombe (UK) and the staggering 25.6% from Perth Australia[8].

Similar studies were done by me in Galle (1974-1976) and in Colombo North (1983-4)[9] by WDH Perera in Kandy (1982-86)[10] and by Prasad Kumarasinghe in Matara in 1992[8]. Eczema/dermatitis was the commonest (30-40%) disease in all studies. Psoriasis is present in around 4% of patients in all these studies. The incidence of scabies showed a significant drop from Jaffna (11%) and Galle (9%) in the seventies compared to the percentages in Kandy in the eighties (2.4%) and in Matara in the nineties (0.88%). This was indeed interesting and probably was a true drop in the incidence of scabies, either through improved living conditions, or a greater awareness and early treatment of scabies. Fungal bacterial and viral skin infectious remained around the same in all these studies.

Thus clinic attendance patterns do give an indication of the increased incidence of cutaneous infections, and the low rate of cutaneous malignanat disease in Sri Lanka and probably shows a drop in the incidence of scabies, over a time period between the 1970's and the 1990's.

The prevalence of skin diseases in the community however needs population surveys. Studies of clinic patterns are subject to many variations and do not reflect the true prevalence of skin diseases. There are only about seven population studies in the world for skin diseases in the recorded literature.

Two prevalence studies of skin diseases in a semi urban community, in Piliyandala[11], and an urban poor community[12] in Kirillapone were conducted in 1998 and 1999 with a team from the University of Jayewardenapura, headed by Dr. Antoinette Perera. The 2 studies together should give an indication of the true prevalence of skin diseases in Sri Lanka.

In the Piliyandala study the houses were selected on an accepted random basis, while in the urban community in Kirilapona all houses in the small-congested complex were included in the study. Skin diseases were common in both studies, 47.6%

and 32.9% in the semi urban and the urban studies respectively. This figure compares well with the other studies worldwide. Skin diseases are very common.

Fungal infections were common. Dermatophyte infections constituted 4% in both studies. Pityriasis versicolor was commoner in the semi urban study. The most significant difference between the 2 studies was in the prevalence of parasitic infections. Pediculosis was very common (6.7%) in the crowded living conditions of the urban poor and rather uncommon in the semi urban (0.22%) community. Scabies was also more common in the urban study.

The prevalence of psoriasis was around 0.4%. The higher hospital figure was probably due to patients seeking treatment at the hospital skin clinics for this chronic unsightly disease. Acne was present in 5.9% of the suburban study and 2.2% of the urban study. No cutaneous malignancies were found in either study.

Fungal and parasitic infections were commoner in the studies from Sri Lanka, compared to those from the UK[13], and the USA[14]. However the figures for these diseases from Tanzania[15,16] and Ethiopia[17] were far higher. Only 50% of persons affected by skin diseases had sought any treatment. This was true of the studies from UK and the USA also. Knowledge of this large section of people with skin disease is important as small changes in the population's perception of the need for medical help can have large effects on the delivery of health care. Prevalence studies would quantify the burden of skin disease and provide a methodological framework for planning dermatological services and for designing and interpreting clinical dermatological research.

Leprosy

In a working draft prepared by the Anti-Leprosy campaign in May 2000[18], the preface states "During the last decade, Sri Lanka has made major steps in eliminating leprosy. Indeed by 1995 the country had achieved the World Health Organization's target for the elimination at a national level – that is, having less than 1 case per 10,000 inhabitants, though pockets of higher prevalence still remain in the eastern and western provinces". I could not agree more. The efforts of the Anti leprosy campaign from 1985, headed then by Dr. Dayamal Devapura, with the most effective social marketing programme, aimed at eliminating the fear of leprosy and the effective WHO based treatment and follow up programme conducted by a dedicated team of doctors and paramedical staff have been responsible for this remarkable improvement.

It was prior to the reorganization of the leprosy campaign that my interest in the disease began and I started treating, counseling, and family contact tracing at the skin clinic Ragama. The defaulterer rate at this clinic was only 6.31%[19] compared to the figure of 56.2% in anti leprosy campaign in the early eighties[20]. Recent research undertaken by the Anti-leprosy campaign has revealed that one of the key obstacles to starting timely treatment falls into the group of socio-cultural factors, – including that of leprosy being managed as a disease apart from others through a specialized campaign and staff. The conclusion of the study on the defaulterer rate of leprosy at the skin clinic Ragama[19] done in 1983-4 was that the lower defaulter rate was at least in part due to their being treated at a general skin clinic and not managed apart.

Lepra reactions occurring in a study population of 1180 patients, treated at the central leprosy clinic in 1994 and 1995, were studied with Dr. Ramya Ragunathan, with the kind permission of the anti leprosy campaign, and 78 patients were found to have had reactions (6.6%). 80% were type 1 reactions, 15% were type 2 and there were 5% mixed reactions. Mixed type 1&2 reactions are not reported from other large series. 92% of the type 1 reactions and 54% of the type 2 reactions occurred in the first 6 months of MDT therapy.

I felt then that a study of the awareness and attitudes to leprosy among various groups of people would be essential to launch a targeted health education campaign. Towards this goal a survey on the attitudes and awareness to leprosy was launched in 1985 with the dynamic leadership of my house officer Dr. K Chandrasekher. 2580 people completed the survey[21]. Significantly low knowledge and attitudes, were seen as expected, among the public of Ragama and Kandy and among schoolchildren, surprisingly and alarmingly in schoolteachers, and disappointingly in minor hospital workers, attendants and labourers. Good knowledge and attitudes were seen among medical students in their clinical years, nurses and a particularly good figure in primary health workers.

A study of the sources of knowledge about leprosy in the entire group revealed that the school and the media were the chief sources. The poor knowledge and attitudes in schoolteachers was therefore of great significance. It was thought vital that in any health education plans on leprosy the schoolteachers and the media personnel should

be the prime target groups. This study may still be of significance in the next phase of the leprosy campaign aimed at the elimination of the disease at district level too, with the integration of the leprosy services into the general health services[18]. I would strongly recommend that the skin clinics now present in most provincial hospitals should be made to play a more pivotal role in training of doctors, referral of suspected cases, diagnosis, and follow up of complications, if the integration is to succeed. A failure to do so may mean the loss of all the gains of the past 15 years.

Other chronic cutaneous infections

15 patients with cutaneous tuberculosis were studied with Prof Amerasekera[22]. This included 12 cases of lupus vulgaris and 3 cases of scrofuloderma. 11 of the patients with lupus vulgaris occurred on the head and neck area. The lesions were all small and left minimal scars. Only one of these patients had systemic tuberculosis.

The first patient with locally acquired cutaneous leishmaniasis in Sri Lanka was reported with Dr Senevirathna in 1992[23]. Subsequently many more reports have been made. Chromomycosis is a not uncommon condition especially in the Ratnapura area and is known for its resistance to treatment. The successful use of Cryotherapy for smaller lesions with Prasad Kumarasinghe and Jayamini Senevirathna[24] and the use of a combination of Ketoconazole and 5Fluorouracil with Ganga Sirimanna[25] were two studies to attempt a treatment regime.

Three patients with infective granulomatous conditions around the nose were described in 1996[26]. One had an erosive and indurated lesion, in the nasal septum and the anterior nares, extending anteriorly to the adjacent skin and posteriorly to the nasopharynx. This resulted in a serosanginous nasal discharge and nasal stuffiness. The histopathology was diagnostic of Rhinoscleroma. The organism responsible is usually Klebsiella Rhinoscleromatis, but our patient grew proteus on 3 occasions, and leaving the possibility of a new pathogen in rhinoscleroma[27]. The other patient presented with a steadily increasing swelling of the nose, later spreading to the adjacent areas. The histology demonstrated the hyphae characteristic of phycomycosis. The third patient with Rhinpsporidiosis in the form of nasal polyps, presented with a granulomatous lesion on the right infra orbital area adjacent to the nose. Histology revealed the spores and sporangia of rhinosporidiosis. Cutaneous lesions are extremely rare in this disease, only 4 cases being reported previously.

Eczema/dermatitis

Atopic dermatitis formed only a small percentage of patients in the clinic attendance patterns in Sri Lanka (1.1%-1.5%)[8,9,10]. In the community studies a prevalence of 1% was recorded in the urban study[12], compared to a low 0.17% in the more rural setting[11]. The figures are much higher in the UK – a clinic prevalence of 5-10% and a community point prevalence of 3-5%[28]. In a study of 50 consecutive patients with atopic dermatitis done at the children's skin clinics in Colombo, with Chintha Perera[29], the percentage of presentation under the age of 1 year was only in 20% of this series compared with 60% in other studies. A possible link between this low incidence and prevalence of breast-feeding was commented on. The aggravating factors for atopic dermatitis in this study were sweat, infections and food.

To fill a dearth on studies on contact dermatitis a study was conducted in 1985, on patients with a clinically probable contact dermatitis in Ragama[30]. 45.8% of these were considered allergic. Of the allergens detected Chromate formed the largest group and Nickel the second. In a later study by Karunasekera and Perera in 1999[31], the incidence of Chromate allergy had dropped to 15.9% and allergies to hair dye, nickel, resins including colophony, and fragrance mix had significant increases, probably reflecting changing life styles.

Folliculitis with eczema of the legs (DCPA)

Dermatitis cruris pustulosa et atrophicans (DCPA) was found in 1.5% of the clinic patients in Galle[9] and 2.3% in Jaffna[2]. This disorder described in Nigeria, has also been reported from India. In a study of 123 cases of DCPA from Galle the characteristic pattern of pustular folliculitis, cutaneous oedema, scale formation, shininess of the skin hypepigmentation and a disorderly arrangement of the hairs with their eventual atrophy were noted. The age of onset was between 16 and 25 years in 83% of the patients. In a histopathological study of 78 biopsy specimens the eczematous changes were mainly confined to the areas of the hair follicles, with the adjacent dermis showing a polymorphonuclear infiltrate in the early stages and a lymphocytic infiltrate in the latter stages invading the hair follicles leading to the destruction of the hair follicles.

Erythematous palmar dermatitis

A peculiar pattern of endogenous eczema characterized by symmetrical dry, shiny erythema with scaling, fissuring and later even contracture formation was described for the first time in 25 patients

in collaboration with Manel Dissanayake[32]. 88.5% of these patients were females and 62% were between the ages of 11 and 20. This condition was commoner in atopies and in those with ichthyosis. In a later study of 100 consecutive patients with a predominantly palmar eczema 30% were found to fit this description and no other causative factor could be found.

Pityriasis rosea

102 patients with Pityriasis rosea were studied with Wijekoon, in 1997[33]. The typical "fern tree" pattern was found only in 35% of the patients, while atypical, especially papular lesions were present in 49% and atypical sites in the face, legs and even in the oral mucosa occurred in a minority of the patients.

Arsenic and the skin

This was an intriguing aspect of some of the studies I undertook, with the interest starting at Colombo south, when we examined a patient in hepatic failure, with diffuse hyperpigmentation of the body, palms and soles with areas of hyperkeratosis on the palms. Arsenic was detected in samples of his hair and nails. 7 further cases presenting to the skin clinic with diffuse and spotty hyperpigmentation, especially of the palms and soles were also found to have arsenic in the hair and nails. Investigation of the sources of arsenic revealed that all our patients were opium addicts who had purchased their supplies from a common source[34].

Water and food were ruled out as possible sources, by examination of the other members of the families. Samples of opium obtained from the same source by one of the investigators, contained unacceptably high levels of arsenic. Data from India has reported the presence of arsenic added to opium in India as an aphrodisiac. So arsenic as a cause of diffuse and spotty hyperpigmentation has to be looked for in our patients.

The next episode was the presentation of a child of 3 years with generalized hyperpigmentation with spotty pigmentation of the palms and soles, mental retardation, and almost total loss of scalp hair, and delayed milestones from 5 months of age, and a peripheral neuropathy with absence of both ankle reflexes. A traditional practitioner had treated the child with a "Ratha Kallke" from 4 months of age to date. The hair and nails of the child tested positive for Arsenic and both the preparations brought by the mother as samples of the Rathe kalke were found to contain arsenic. Mental retardation, encephalopathy, and peripheral neuropathy in children following chronic arsenic poisoning have been reported before from Thailand with the source being well water.

Erythroderma was studied at 2 different periods with Dharmagunawardena (1977)[35], and Chalukya Gunasekera (1995)[36]. Both these studies showed a high percentage of patients in whom no cause could be found. A large number of these patients had taken some form of traditional medication for a considerable period of time and had as one of the main clinical features a severe generalized pigmentation. One patient in the later study was found to have arsenic in the hair and nails. Mycosis fungoides and malignant lymphomas were found to be the causative factor in 3 of the patients in the earlier study.

In a study with Dr Chandani in 1998[37], a prospective and comparative study was done of 22 consecutive patients with erythroderma and a history of taking traditional medication, and a control group of patients who had no erythroderma. Analysis of hair and nails for arsenic was done in both sets of patients. Five out of the 22 patients with erythroderma and a history of traditional medications tested positive for arsenic in the hair and nails, while none tested positive in the control group. Of the five patients who tested positive for arsenic we were able to obtain the traditional medication from 2 patients and both samples of the traditional medication tested strongly positive for arsenic. There are no recent references to arsenic as a cause of erythroderma. We contend that in patients with idiopathic erythroderma, with a history of traditional medication, arsenic must be thought of as a possible cause.

Macular hyperpigmentation and lichen planus

In a study of 32 consecutive cases of patchy macular hyperpigmentation of unkown aetiology, done with Omala Wimalarathna[38], we found hydropic degeneration of the basal cells in 14 cases, pigment incontinence and a lymphocytic infiltrate with disorganization of the collagen in the upper dermis in a further 10 cases. We believed that these histological changes were compatible with a resolving lichen planus and agreed with the findings of Bhutani[39], that these were a type of macular lichen planus (lichen planus pigmentosus). Others doubt the lichen planus like aetiology and prefer to call these patients spontaneous acquired macular hyperpigmentation[40].

In a study of 112 patients with lichen planus[41], at the Colombo South hospital clinic we found that 50% of the patients developed hypertrophic patches

on the legs, an unusually high figure. In a study of glucose tolerance done in 64 patients with lichen planus, 3 were found to be diabetic while 20 had only a single blood glucose elevation above 170mg/100ml at 30 or 60 minutes after the ingestion of glucose. In all these 20 patients the intravenous GTT was normal, casting doubt on the then held belief that many of those with lichen planus were diabetic or impending diabetics[42].

Psoriasis – social and psychological effects

Psoriasis is typical of the psychological and social problems of skin diseases. In a study of 200 patients done at 2 different time periods[9], 50% of the patients avoided many forms of social activity due to the disease and 70% of the patients felt that casual contacts tented to look at them with revulsion and shun them. The positive feature in our study was that the family (in 97%) and the work place (in 82%) were supportive. In a recent study of 76 patients with psoriasis 53% were depressed and 51% avoided social functions. 21% felt that their job performance was affected and 8% had lost their jobs due to psoriasis[43]. It was felt that sufficient cognizance should be taken of this aspect during the treatment of psoriasis.

A study on therapy of psoriasis with Calcipotriol in 50 consecutive patients, it's efficacy and side effects on the pigmented skin was done with Damayanthi Bandara[44]. Though 78% showed a good or partial response, the irritant reactions on the lesional and perilesional skin in 44%, was a far higher figure than in previous studies.

Blistering diseases of the skin

In a review of blistering diseases in Sri Lanka, Ganga Sirimanna found that contrary to the figures in the west 59% of all autoimmune diseases were due to pemphigus, and only 19% to bullous pemphigoid[45]. Chronic bullous dermatosis in children (CBDC) was the commonest auto immune dermatosis in children[46].

Pemphigus is a necessarily fatal disorder unless treated effectively. Ganga Sirimanna found that our patients with pemphigus needed large doses of steroids (prednisolone 60 - 100mg a day) for the initial control of the disease. An intermittent high dose dexamethasone – cyclophosphomide (DCP) regime has been used with considerable success in India. A study of the effects of this regime on 25 of our pemphigus patients, showed a remarkable success, with 6 patients in remission, and the rest achieving control in a short period of 3 months[47]. No major complications were encountered. It was therefore decided to do a controlled randomized study on patients with pemphigus, with one group on the DCP pulse regime and the control group on the conventional therapy with prednisolone. At present 55 patients are on the study and preliminary results seem to show a marked difference in response in favor of the pulse therapy.

The inherited mechano-bullous disease Epidermolysis bullosa has been a particular fascination of mine. Early in the investigative stages of the drug Etretinate, I used it to treat a patient with epidermolysis bullosa dystrophica on the basis that increased collaginase activity was partly responsible for the subepidermal split and that in some cases the collagenase inhibitor action of phenytoin sodium was successful. The retinoids also were reported to have collagenase inhibiting activity and its use in this patient resulted in a remission and an exacerbation again when she omitted the drug temporarily[48]. She is now relatively free of the disease, successfully married and doing a responsible job in Sweden.

In Saudi Arabia I reported a patient with autosomally recessive severe form of epidermolysis bullosa simplex, with many dystrophic features such as mucosal involvement, nail atrophy, milia and an exuberant granulation tissue, suggesting junctional features[49]. This could not be explained at that time. The new findings of transmembrane attachment proteins in the region of the hemi-desmosomes offers a possible site for the defect.

Sweet's syndrome (acute febrile neutrophilic dermatosis)

This syndrome occurs as purplish red coloured plaques of acute onset and is characterized by a dense neutrophilic infiltrate in the dermis, and have been associated with many underlying conditions such as leukaemias, lymphomas and inflammatory bowel disease. We recently described 2 cases associated with lepra reactions and another associated with pulmonary tuberculosis[50]. These associations are very rare. While in Saudi Arabia we were able to comment on the successful treatment of 2 cases of Sweet's syndrome with doxycycline, a new therapy for this condition[51].

Subcutaneous panniculitic T cell lymphomas

Two patients both females in the 20s were diagnosed as subcutaneous panniculitic T cell lymphoma. One of these patients had a haemophagocytic syndrome. In 1992 this type of T cell lymphoma was

recognized by the international lymphoma study group as a subtype of peripheral T cell lymphoma. In 1998 when these cases were reported there were only about 30 such cases reported worldwide. I like to think that these cases were one of the instigating factors for the establishment of the Sri Lanka study group on cutaneous lymphomas in 1999.

Multiple myeloma and the skin

We retrospectively reviewed the records of 58 patients with multiple myeloma, diagnosed and treated at the Riyadh Armed Forces Hospital. Cutaneous plasmocytomas, petichae and eccymosis, herpes zoster, cutaneous necrosis, and vasculitis, pruritus, and diffuse alopecias and a case of subcorneal pustular dermatosis (SCPD) were among the cutaneous lesions found. The case of SCPD was the presenting feature of a case of IGA myeloma, and was the 5th report of it's kind in the literature[52].

Cutaneous drug reactions

Fifty eight cutaneous adverse drug reactions seen at the National Hospital Sri Lanka over a period of 12 months, were reported with Rohini Fenandopulle[53]. The commonly encountered cutaneous drug reactions were macular popular and urticarial reactions. The serious reactions included toxic epidermal necrolysis, Steven Johnson syndrome, angioedema, and erythroderma. The commonly implicated drugs were non steroidal analgesics, anti convulsants and anti microbials.

In view of the serious cutaneous affects encountered in the dermatology unit following anti convulsant therapy a study on the cutaneous adverse effects of anti convulsant drugs was started in 1999 and is under analysis now.

I have spoken of the development of dermatology as a specialty in Sri Lanka over the past 32 years and some of my small contributions to the advancement of knowledge in the field of dermatology in Sri Lanka. Much more needs to be done. We need to have more equipment and more investigative techniques. The laboratories need to keep pace. A regular immunoflurescence and electron microscopy service is a must. Dermatology is a young dynamic and highly scientific branch of medicine and a new, energetic and highly knowledgeable generation of dermatologists are ready now to take dermatology care and research into the future in Sri Lanka.

I can remember our fledging and unsuccessful attempts to start an Institute of dermatology. Due to the efforts of Dr. T. T. Kasturiratna, there was an attempt to start an institute. This was to be a separate institute in close proximity, to the National Hospital of Sri Lanka, on land to be made available by the then government. Financial constraints prevented us from doing so. I can also remember my poor efforts at trying to obtain the old eye hospital premises for this purpose, with Dr. Terrence Silva, the then Director of the National Hospital. However the needs of the orthopedic and trauma units obviously took precedence under the circumstances.

With the efforts of Dr. W D H Perera we have managed to get much needed equipment to the dermatology department. We now have a state of the art UV whole body machine and a Nd YAG Laser. These are essential prerequisites for any dermatology department and we hope more will be made available in due course. Through the efforts of Dr. J B Peiris the Director of the postgraduate institute of medicine, we have had numerous teaching aids and a multi head microscope.

I have to thank so many people to whom I owe so much. Dr. Keerthi Weerasekera and Dr.W D H Perera with whom I was able to forge a unique relationship at work. We shared our ward, our staff, and our knowledge, in the care of our patients. To all those who did a period of training with me and are now very eminent dermatologists, to all my house officers through different periods, to many of the consultants in different fields, my ward staff – I thank them all. I thank all of you for waiting all this time to listen to someone else's journey.

To my mother who, through the greatest of sacrifices made me a part of this profession, I owe the deepest gratitude: And to one who stood by me and encouraged me, during all these 32 years and more, through thick and thin, through trials and tribulations, with great equanimity, – my wife Anoja. I fondly remember here my children, for the strength and stability to continue.

I have now reached an important stage in my journey through dermatology. I only hope that this will only be a turn in a new direction and a chance to do things differently.

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