DERMATOLOGY ON ACTIVE SERVICE
WITH A PLEA FOR RE-ORGANIZATION OF THE SKIN DEPARTMENT.

BY CAPTAIN JOHN SAVAGE,
Royal Army Medical Corps.

This account is based on cases seen during the Tunisian campaign, roughly March, April and May, 1943. During this campaign all skin cases evacuated eastwards, i.e. practically the whole of the dermatological cases of the 8th Army, were treated at the one hospital in Tripoli. It is unusual for all skin cases to go to one hospital and this arrangement provided me with a unique opportunity of seeing the types of cases requiring evacuation during active operations. The skin department was normally 100 beds, expanded to 200 during this period.

The actual number of cases admitted was 1,298. This proved to be 35 per cent of all medical admissions and demonstrates clearly the loss of manpower and interference with Army routine caused by skin diseases. The amount of interference is actually much higher than this, as any M.O. will confirm that at least 7 out of 10 men attending sick parade do so because of skin trouble.

THE CASES.

These are listed below in Table I showing percentage of total. Table II shows the types of cases attending the out-patient's department during this period. They are shown in order of frequency.

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Per cent of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impetigo</td>
<td>36</td>
</tr>
<tr>
<td>Furunculosis</td>
<td>14.1</td>
</tr>
<tr>
<td>Scabies</td>
<td>13.3</td>
</tr>
<tr>
<td>Dermatitis (all causes)</td>
<td>8.7</td>
</tr>
<tr>
<td>Mycotic infections</td>
<td>7.5</td>
</tr>
<tr>
<td>Eczema (all types)</td>
<td>4.7</td>
</tr>
<tr>
<td>Psoriasis</td>
<td>4.5</td>
</tr>
<tr>
<td>&quot;Desert sores&quot;</td>
<td>3.2</td>
</tr>
<tr>
<td>Herpes zoster</td>
<td>2.3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Per cent of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hyperidrosis feet</td>
<td>1.9</td>
</tr>
<tr>
<td>Urticaria</td>
<td>1.8</td>
</tr>
<tr>
<td>Pruritus ani</td>
<td>0.7</td>
</tr>
<tr>
<td>Acne vulgaris</td>
<td>0.4</td>
</tr>
<tr>
<td>Lichen planus</td>
<td>0.3</td>
</tr>
<tr>
<td>Pityriasis rosea</td>
<td>0.3</td>
</tr>
<tr>
<td>Sycosis barbare</td>
<td>0.2</td>
</tr>
<tr>
<td>Ichthyosis</td>
<td>0.1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Per cent of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mycotic infections</td>
<td></td>
</tr>
<tr>
<td>Eczema (all types)</td>
<td></td>
</tr>
<tr>
<td>Dermatitis (all types)</td>
<td></td>
</tr>
<tr>
<td>Warts</td>
<td></td>
</tr>
<tr>
<td>Impetigo</td>
<td></td>
</tr>
<tr>
<td>Psoriasis</td>
<td></td>
</tr>
<tr>
<td>Alopecia areata</td>
<td></td>
</tr>
<tr>
<td>Furunculosis</td>
<td></td>
</tr>
<tr>
<td>Eczema</td>
<td></td>
</tr>
<tr>
<td>Acne vulgaris</td>
<td></td>
</tr>
<tr>
<td>Urticaria</td>
<td></td>
</tr>
<tr>
<td>Lichen planus</td>
<td></td>
</tr>
<tr>
<td>Erythema multiforme</td>
<td></td>
</tr>
<tr>
<td>Lupus erythematosis</td>
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</tbody>
</table>

It will be seen that 63.4 per cent of admissions were for pyogenic skin diseases including scabies. Seven types of case, namely, impetigo, furunculosis, scabies, dermatitis (all causes), mycotic infections, eczema (all types) and psoriasis, form 88.8 per cent of the series and briefly the treatment and observations on these will be considered.

IMPETIGO.—This was the commonest cause of admission. Fifty consecutive cases were cultured with the following results. *Staphylococcus aureus* 78 per cent, *Staph. albus* 17 per cent and non-haemolytic streptococcus-5 per cent.

Treatment.—Whilst in charge of a similar skin department in Egypt, all cases were treated with 5 per cent sulphonamide in calamine lotion if very moist, followed by 5 per cent sulphonamide paste. Trial was also made with sulphapyridine and sulphathiazole lotions and pastes.

During the three months of the Tunisian campaign all cases were treated with starch poultice if very crusted, simple lotions and pastes, e.g. sulphur 2 per cent in calamine lotion, Lassar's paste and paste flav. (10 gr. to ounce of hydr. oxid. flav.).

Unlike most other writers on the use of sulphonamide locally in impetigo I found, on looking over personal case cards, no difference in the number of days required to cure. Sulphonamide by mouth, however, proved very useful in severe cases.
Another point which arises in war dermatology as against similar cases in civilian practice stressed by Lieutenant-Colonel Tate (M.E. Adviser in Dermatology) is the fact that you may sensitise a patient to sulphonamide which may, at a later date, have grave consequences.

He has seen several cases where a patient was treated for impetigo by his M.O. with perhaps sulphonamide powder. A week to ten days later the same soldier became a casualty and was treated routinely with sulphonamide by mouth. Lieutenant-Colonel Tate reports that these cases often react as if they have been sensitised to sulphonamide, developing high fever, widespread erythemas, vesicular and bulbous eruptions. These patients are very ill and added to the effects of their wound the sensitization may just tip the scales against them. Why then should you deprive a soldier of a life-saving drug when his skin condition would clear up as quickly without taking this risk?

FURUNCULOSIS.—A very common cause of admission to hospital; every Army sick parade has its quota of boils.

Treatment was very, simple and consisted in swabbing the lesions and surrounding skin with 1:1,000 hydrarg. perchloride three times a day with dry dressings. The use of fomenfs was discouraged. If very severe with lymphangitis and adenitis a course of sulphonamide was prescribed. In persistent and recurrent cases an autogenous vaccine was prepared, with indefinite results.

SCABIES.—This formed 13 per cent of cases. Scabies tends to be over-diagnosed in the Army. Most cases were infected. No benzyl-benzoate was available and treatment was by ung. sulphur B.P. or Marcussen’s ointment. The routine was, first day, hot bath with scrub, followed by application of ointment from the neck downwards; second day, more ointment; third day, ointment in the morning and cleansing bath in the afternoon. All kit passed through the disinfector and discharge, in an uncomplicated case, followed on the fourth day.

DERMATITIS.—The various causes are listed below:

<table>
<thead>
<tr>
<th>Type of dermatitis</th>
<th>Per cent of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infected</td>
<td>59</td>
</tr>
<tr>
<td>Seborrhœic</td>
<td>20</td>
</tr>
<tr>
<td>Venenata</td>
<td>18</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of dermatitis</th>
<th>Per cent of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic solar</td>
<td>1</td>
</tr>
<tr>
<td>Exfoliative</td>
<td>2 cases</td>
</tr>
<tr>
<td>Artefacta</td>
<td>1 case</td>
</tr>
</tbody>
</table>

Treatment in dermatitis infectiosa (the commonest type) usually consisted of dressing with 2 per cent sulphur and calamine lotion or methyol 2 per cent in calamine lotion passing on to a simple paste and finishing with a cream.

MYCOTIC INFECTIONS.—All types were met with Tinea cruris, circinata and versicolor. Treatment was by the usual textbook preparations.

Special mention must be made of epidermophytosis of the feet. This diagnosis was very commonly made in the M.E., the condition being definitely over diagnosed with unfortunate results. Most of these cases were simple pyogenic intertrigos of the toes and, since having a taste of a soldier’s life under active service conditions, it is easy to understand how the condition begins. A little dirt collects between the toes causing friction; this produces irritation with possible scratching and a small focus of infection is started. One or several toes may be affected. When he eventually reports sick his M.O. in many cases diagnoses epidermophytosis and treats the same with a fungicidal. This does not clear up the condition and, as it is common knowledge that epidermophytosis is stubborn to treat, the fungicidal is often applied with renewed vigor or in greater strength. Most of these cases eventually land in hospital badly infected with inguinal adenitis.

The treatment carried out was pot. permang. cleansing baths with eu sol dressings if very purulent, gradually passing through the stages of lin. calamine, ichthyol-calamine lotion and Lassar’s paste. The time taken to clear up completely was considerable and relapse was common unless a prolonged period of convalescence followed.

ECZEMA.—Treatment varied with the various stages, viz. erythematous, vesicular, weeping, dry and scaly, and lichenified. The preparations used in these stages were, lotio calamine, ichthyol 2 per cent in calamine lotion, Lassar’s paste, tar paste, and crude coal tar. Autohaemotherapy was also tried.
Psoriasis.—This troublesome condition seems to be just as common in the M.E. as at home. All the usual types were seen and no aetiological factor was found.

Treatment was by ung. chrysarobin B.P. with good results. The following preparation was used if the scalp was affected. Ol. cadinæ 12 per cent, ac. salicyl. 4 per cent, ung. hydr. ammon. 6 per cent, in olive oil.

Desert Sores.—So much has been written about this subject giving results of cultures, aetiology, vitamins and treatment that it was only after careful consideration that I decided to include my experience and ideas in this paper. However, when one realizes that 42 per cent of all admissions to the skin department in Egypt during three winter months was for "Desert Sores," probably a good deal higher in a corresponding period in summer, one must ask oneself the cause of this common complaint.

In my opinion there are three reasons, viz. (i) individual susceptibility to sunlight; (ii) water; (iii) medical care.

The desert sore is definitely commoner in the fair-skinned freckly type. These individuals take the sun badly, their skin cracking and blistering on exposure to sunlight and, although the so-called primary type of lesion does exist, by far the majority of sores start as a minute infected abrasion commonly on the back of the hands and front of knees.

In the desert it was difficult to spare enough water for frequent washing and infection was often made worse by the countless flies. Also, from information received from M.O.s who served throughout the desert and Tunisia, due to the vast expanse of desert with few roads, medical units were often widely separated, resulting in many men being unable to attend early and regularly for dressings. What then started as a small infected abrasion would gradually develop into a chronic ulcerated sore.

Fifty consecutive cases were cultured, results being over 70 per cent of cases Staph. albus or Staph. aureus, the remainder being, in order, B. coli, β-haemolytic streptococcus and diphtheroids. One case from which K.L.B. was cultured was met with but not in this series.

Treatment carried out was eusol dressings, b.d., if very purulent, followed by a paste consisting of 5 per cent sulphonamide in zinc paste or an easy one made with crushed up tablets and lotio acriflavine.

Finally, I feel that some re-organization of the Skin Department is required to ensure early diagnosis and the best possible treatment as the present arrangement, whereby the Skin Department is the "Cinderella" of the Medical Wards, leads, amongst other things, to excessive use of dressings, pastes, lotions, etc., largely due to too frequent changes in medical personnel.

The first essential, however, is for unit M.O.s to send all unusual cases early to a recognized skin centre where the advice of a specialist can be obtained and, very important, where the proper preparations are available.

I feel that something after the lines of the V.D. Centres attached to a General Hospital is what is wanted. You would then have a M.O. who has had previous hospital experience, a specially trained skin staff and a laid down minimum of equipment.

Such an arrangement would make for earlier diagnosis, more expeditious treatment and quicker return to duty, with consequent saving of man-power and material.

A CASE OF EXTRADURAL HÆMORRHAGE PRODUCING MUTISM AND HEMIPLEgia.

By Captain A. D. Leigh, M.R.C.P., Royal Army Medical Corps.

A 30-year-old Hindu was returning home with his family on the night of November 11, 1943, when he was set upon by dacoits. He was beaten over the head with lathis (long bamboo staffs) and then thrown down from his bullock cart, beaten further, and left unconscious on the ground.
Dermatology on Active Service: With a Plea for Re-Organization of the Skin Department
John Savage

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