

Towards a Global Community of Care

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Photoprotection advice for children with albinism. Photo courtesy of Mafalda Soto

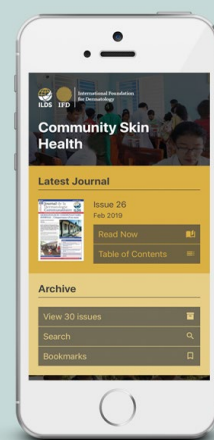
As the world's largest and oldest organization dedicated to global dermatology, the International League of Dermatological Societies (ILDS) strives to attain the best possible skin health for all people in the world and officially works in collaboration with the World Health Organization. We know that dermatologists are uniquely positioned to provide expertise for patients with skin diseases by drawing on clinical experience, advanced education, and innovative research. Nevertheless it's equally clear that the global burden of skin disease can only be managed through the efforts of a broad spectrum of frontline healthcare workers and professionals. The International Foundation for Dermatology (IFD) undertakes the humanitarian activities of the ILDS for people who are not otherwise able to access essential care for their skin disorders. One of the key aims of the IFD is to build capacity amongst frontline care providers within their own communities, wherever they may be, and this publication has been a much valued educational and

communications tool since it was founded by Dr Paul Buxton in 2004. The ILDS is proud to support the transformation of this journal to its new moniker, "**Community Skin Health**" and renews our commitment to publish it as the IFD's official journal in tandem with the new online Community Skin Health App. On behalf of the 200,000 global dermatologists that the ILDS represents, we are deeply grateful to our editors Chris Lovell and Michele Murdoch for their leadership and ongoing dedication to "Skin Health for the World".

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REFUGEE SKIN HEALTH IN LEBANON:

An Interview with Professor Chris Griffiths

Abstract

ILDS Board Member and renowned dermatologist Professor Chris Griffiths OBE (University of Manchester, UK) shares his experience of visiting and providing dermatological care to Syrian Refugees in the Bekaa Valley, Lebanon, as well as his wider thoughts on migrant health.

Key words: refugee skin health, migrant health, Lebanon.

What is the background to the Syrian refugee crisis in Lebanon?

Since the onset of the civil war in Syria in 2011, Lebanon has received at least 1.5 million Syrian refugees – 1.1 million of whom are registered with the United Nations High Commission for Refugees (UNHCR). This massive influx has put a strain on Lebanon's health and education sector as well as its water, sanitation and utility services. This has led to rising tensions between refugees and host communities.

What sparked your interest in migrant health and how did you become involved?

I have developed a deep interest in the plight of refugees and the inequality of care in developing nations; this has been informed by the work of the Regional Dermatology Training Centre (RDTCC) in Tanzania and the International Foundation for Dermatology's Migrant Health Dermatology Working Group. Moreover, I have worked in the field of dermatology for over 35 years. Over this period, I helped to improve dermatological care in the United Kingdom and gained a wide range of clinical, research and administrative skills in the process. I wished to ascertain whether this skill-set would enable me to contribute to the welfare of refugees, which is why I wanted to volunteer my skills as a dermatologist.

In July 2017, I was invited to give a series of lectures at the American University of Beirut (AUB) by former ILDS Board Member (2007 – 2015), Professor Abdul-Ghani Kibbi - the Chair of Dermatology at AUB and Deputy Chief of Staff for Medical Staff Affairs. Graciously AUB invited me to return as the prestigious Fuad Farah Visiting Professor in July 2018. Whilst I was deeply honoured, I wanted to use this opportunity to make a difference. Therefore, I accepted AUB's invitation with a request to visit and provide dermatological care at the Syrian Refugee camps in Lebanon, which they kindly accepted and arranged.

Could you tell us more about your journey to the refugee camps?

I arrived in Beirut on 8 July 2018 and over the ensuing three days spent time staffing clinics in the department of dermatology at AUB, teaching residents and medical students in the process and delivering a series of lectures to the medical staff. We were able to plan the logistics for the humanitarian mission to the Syrian camps during this time including boxing up the necessary pharmacy supplies to take with us. The department administrator Kathia Kozman was fundamental to this logistical exercise. I departed for the camps on 12 July accompanied by Professor Kibbi, two of his senior residents and a primary care physician who had prior experience in the refugee camps. The two camps are in the



Fig 1. Refugee camp Anjar, Bekaa Valley, Lebanon

Bekaa Valley close to the Syrian border (Fig 1), an open plain without shade and thus swelteringly hot in summer and very cold in winter.

What was life like for the people of the Anjar and Saad Anyil refugee camps?

The conditions vary from season to season and year to year, particularly as the number of refugees continues to increase. Therefore, I am not able to give a definitive answer.

From my observations the camps were relatively secure and there was access to clean running water and food. However, many residents had to work in the fields or in neighbouring villages to ensure they ate a broader diet, as food was not diverse. Overcrowding was a key issue as families, often comprised of five or more people, lived in small shelters made of wooden poles, canvas and woven sheets. Each small shelter contained one main room that doubled as a living room and bedroom, a small kitchen area with an open stove fire, a washing and storage area and a walkway.

Even so, people made the best of the conditions, which was reflected in the way they presented themselves. One thing that stood out to me, time and time again, was the effort that people put into their appearance and how they were perceived by others, particularly their neighbours and friends. The residents of Anjar and Saad Anyil refugee camps were in many ways no different than the patients I see in my clinics in Salford (Manchester, UK). They are concerned about their skin and their appearance (young women asking about photoprotection to prevent wrinkles for instance) and are worried particularly about skin disease in their children.

For many, the future was also a key concern as most yearned to go home to the lives they knew. However, this was not possible, even for those who were willing to make the journey back. For example, I treated a woman in her mid-40s and her 18-year-old son; both discussed their overwhelming desires to return to Aleppo – even in the midst of the civil

war. However, they were not able to as her son, now of age, would be conscripted into the Syrian National Army. In order to ensure that he was not conscripted, she was informed that she would have to pay approximately US\$10,000 – a sum greater than their yearly income. Even so, they remained hopeful that things would change, and they would once again return home. Overall, people were resilient, spirited and hopeful, which is important to note as we often perceive refugees through their circumstances, either as helpless victims or as burdens.

Education is seen as a way out and is greatly valued. However, most children and young adults, including those born in the Lebanese camps, do not have access to formal education channels as they cannot enrol in local schools. Nonetheless, there was a small school in one camp that provided education, but spaces and resources were limited. Despite these challenges, the desire for education remained high.

What were the dermatological issues you encountered and what were the causes? Were there sufficient services and programmes to meet the medical/dermatological needs of these communities? If not, what are the gaps and what support is needed?

Syrian refugees in Lebanon, much like their counterparts across the world, have limited access to healthcare services. Given this, the *Beyond Association* and other non-governmental organisations (NGOs) have established mobile clinics to help fill this gap. However, these clinics are often overstretched, underfunded and under-resourced as I witnessed during my time as a volunteer medic with the NGO *Beyond Association*.

Given the nature of the Syrian conflict, I was informed that we should look for signs of torture, which I did not come across. However, given the delicate nature of this topic, it was hard to gauge and approach – despite excellent translation by the nurse who accompanied me in the clinic.

As part of the *Beyond Association's* mobile dermatology clinic, the team and I helped to manage over 130 patients at both the Anjar and Saad Anyil refugee camps, from newborn babies to the elderly (Fig 2). During this process, I came across a wide range of dermatological conditions, including head lice, leishmaniasis, atypical mycobacterial infections and scabies, as well as skin conditions commonly seen in the UK such as basal cell cancer, psoriasis, eczema and acne, among many others. The causes of the above conditions are as wide ranging as the illnesses themselves, but some were as a result of the overcrowded and harsh conditions of the camps. For example, there were many scalds/burns cases, particularly amongst young children as a result of playing and/or sleeping in the kitchen area of their homes where oil or water were heating on a low hob near ground-level.

We transported all our medical supplies, mainly creams, ointments, emollients, anti-fungal agents and antibiotics with us from AUB and set up an outdoor pharmacy. All patients were deeply appreciative as a prescription service



Fig 2. Professors Griffiths and Kibbi examining a patient in the mobile clinic, Bekaa Valley, Lebanon.

was not available. For more serious cases, however, we were able to arrange further treatment in Beirut – thanks to a small fund provided by AUB. For example, one patient – a woman in her mid-40s – had a large basal cell cancer on her scalp due to radiotherapy treatment she received for tinea capitis as a child. Whilst the camp had basic healthcare facilities, it was not enough to treat conditions such as hers. This fund gave her a chance, but for many this option is not available as resources are overstretched.

Do you plan on volunteering in the field again? What are your thoughts on the role of dermatologists, dermatological societies and the ILDS in migrant/refugee health?

I hope to visit Lebanon again as it was a worthwhile and life-changing experience. I came away from it feeling humbled, particularly seeing how people live there and the challenges they faced. I also felt I made a difference and am inspired to do more. A key aspect for me was the dermatological skills I had acquired from four decades working in the National Health Service (NHS) were relevant and transferable to the migrant camp “field situation”. As a result of my trip, I have joined the ILDS's Migrant Health Working Group and in December 2018, I will visit Myanmar to meet with local dermatologists and those responsible for national healthcare to forge links and perhaps improve care for displaced groups including Rohingya refugees.

Through ILDS DermLink, the ILDS is helping to improve access to care for under-served communities, particularly refugees. There will be a workshop on migrant health at the World Congress of Dermatology in Milan in June 2019. Regarding migrant health, many challenges remain but raising awareness of the difficulties and the positive impact that those of us who are trained dermatologists can make will help improve the management of skin disease at least.

Cutaneous Leishmaniasis in Naivasha District, Rift Valley, Kenya

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Abstract

Introduction; Cutaneous leishmaniasis is a major public health concern and its prevalence is estimated to be 12 million worldwide. In Kenya there are several foci of cutaneous leishmaniasis, namely in the Rift Valley, Central and Western provinces.

Objective; We sought to carry out a survey on the presence of cutaneous leishmaniasis in two locations where cases were previously reported within the Rift Valley province in Kenya.

Methodology; The community was informed about the survey, which included five different schools in the two areas. The diagnosis was made clinically.

Results; One thousand eight hundred and seventy five (1,875) individuals were examined for evidence of cutaneous leishmaniasis. The overall prevalence was found to be 3.9%. The clinical types identified in these areas were cutaneous, mucocutaneous and disseminated leishmaniasis. The cutaneous presentations varied from papules to ulcerated and crusted plaques with the sizes ranging from 0.5cm to 15cm in diameter. The presence of *Leishmania* was histologically confirmed in 25 of the 42 biopsies taken.

Conclusion; The survey has proved that cutaneous leishmaniasis is a public health concern.

Key words: Cutaneous leishmaniasis, prevalence, Rift Valley, community, domestic animals.

Introduction

WHO has identified leishmaniasis as one of the emerging and uncontrolled diseases, hence the World Health Assembly has advocated a concentration of resources on its control. Approximately 12 million people are infected worldwide¹. It is endemic in 88 countries in the world with 350 million at risk. In several countries the prevalence is underestimated and it is on the rise.

Leishmaniasis causes a spectrum of clinical syndromes in humans which range from cutaneous lesions to systemic manifestations. It can present in three forms: cutaneous, mucocutaneous and visceral^{2,3}. Of these different forms cutaneous leishmaniasis is the mildest form and can clinically present as localised, diffuse, recidivans or post kala-azar dermal leishmaniasis.

In Kenya, the Central, Western and Rift Valley provinces have several foci of cutaneous leishmaniasis; it has been detected in Samburu, Isiolo, Laikipia, Nakuru and Nyandarua districts⁴. In these areas *Leishmania tropica* was identified as the main causative parasite, confirmed in a species identification study by Samuel Odiwuor *et al.* on 25 samples taken from the same region⁵. In other parts of Kenya the causative parasite is different; in Elgon district (western Kenya) the species is *Leishmania aethiopica*, while in Baringo (north Rift valley) it is *L. major*.

Objective

The aim of this study was to carry out a survey on the presence of cutaneous leishmaniasis in 2 locations previously reported to have cases within the Rift Valley province. No surveillance study on cutaneous leishmaniasis has been done in this area.

Methodology

The survey was carried out in two areas that had been identified by Sang *et al.* in 1993 as one of the foci of cutaneous leishmaniasis (Gitare and Kiambogo). These areas were also selected because of cases that were being encountered during the medical outreach services and the increased numbers of cutaneous leishmaniasis patients seen at the Rift Valley provincial hospital.

The community was informed through the chiefs and opinion leaders about our study. Description of the lesions during the survey was made easier as the people in these communities referred to the lesions as 'tinea' that did not respond to therapy given in hospital. Five schools in Gitare and two schools in Kiambogo (less populated) were selected as points where people would come for screening. In the schools all the students were screened. From the community all those adults and children (not of school age) who suspected they



Fig 1. Mucocutaneous involvement.



Fig 2. Facial plaques in a child.

had cutaneous leishmaniasis who came for screening were examined. For those who were clinically diagnosed to have cutaneous leishmaniasis a questionnaire was completed to answer questions regarding how long they had had the condition, what medications they had used and whether other family members were affected. They were then examined to determine the clinical type of disease. Skin biopsies were taken in 42 patients.

During the survey, those who were diagnosed to have different skin conditions were given appropriate therapy.

Home visits were done in both areas to try and establish if the domesticated animals were reservoirs. Selection of the homesteads was done by convenient sampling. This also gave us a chance to find more cases of leishmaniasis and also survey the environment for other possible animal hosts.

A limitation of this study was that the diagnosis was made clinically.



Fig 3. Ulcerated plaque on the cheek.

Results

1875 individuals were examined over five days for evidence of cutaneous leishmaniasis. 13 homesteads in Gitare and 4 homesteads in Kiambogo (less populated) were also visited.

125 individuals were affected by cutaneous leishmaniasis (active and scar lesions), with a male to female ratio of 1:1.2 (females-58, males-67). Seventy three (73) had active lesions giving a prevalence of 3.89%, while 52 had scars. The age range of those affected was from 8 months to 87 years, with a median of 12 years (mean-16yrs, mode 10yrs).

All those affected with the disease had no idea concerning its



Fig 4. Mutilating facial lesions with areas of depigmentation.

cause. Of those affected, 22 patients had at least one other family member affected by leishmaniasis. One patient said that four other family members were affected.

Lesions (active and scars) were mainly found on the face (103). The other sites affected were: lips (5), ears (5), leg (3) and upper limb (7). Twenty-nine individuals with active lesions complained of symptoms; 86.2% complained of itch while 10.34% had pain and 3.45% photophobia. The *Leishmania* parasite was identified in 25 of the 42 biopsies.

Most of those with active lesions (68.49%) had been treated at nearby health facilities or used herbal medicines with no change.

Table 1	
Number of lesions per individual in the 73 patients with active disease	
Number of lesions	Number of individuals
1	64
2	7
4	1
5	1

None of the domesticated animals showed signs of cutaneous leishmaniasis during the home visits although many hyraxes were encountered in the environment.

The number of lesions per individual is shown in Table 1, while Table 2 shows the frequency of the different clinical presentations, some of which are illustrated in Figs 1-7.

Continued overleaf...

Table 2

Different clinical presentation of the lesions

Type of lesion	Number of individuals with that type of lesion
Papule	3
Plaque	37
Crusted plaque	21
Plaque with central ulcer	6
Plaque with involvement of the mucous membranes	2
Scar with active lesions (papules)	4
Scar	53

Discussion

Although not a population-based study, our survey's finding of a prevalence of 3.89%, suggests that cutaneous leishmaniasis is indeed an important health concern in this area of Naivasha district in the southern Rift Valley province of Kenya. It further confirms the case reports of Sang *et al.* in 1993. The prevalence has apparently increased or it may have been under-reported. In Asia a number of studies have been done showing prevalences of 4.16%⁶ and 6.93%⁷ in the north Waziristan district of Pakistan, while it is as high as 50.89% in Dir district.

In this survey it was found that males and females were equally affected, in contrast to the findings of Harith Saaed Al-Warid *et al.* where most cases were detected in men and boys⁸.



Fig 5. Extensive papular lesions.



Fig 6. Grouped papular lesions in a child.

Age was not a factor in contracting cutaneous leishmaniasis, although it was more common in the younger age group. However, the skew towards the younger age group could be because we examined all the children in the schools we visited.

It was interesting to note that the disease could affect more than one member of the same family, raising the question of genetics and immunity against *Leishmania*. This could also explain the different clinical manifestations, different sizes and duration of active lesions.



Fig 7. Extensive facial plaques.

Cutaneous leishmaniasis is an old disease but unknown to many, explaining why the patients were being treated for wrong diagnoses made by the health workers.

The symptoms of pain and photophobia in this study were not surprising as they could be due to secondary infection and involvement of the ocular mucous membranes, respectively. Why some individuals experienced itch is unclear, although

it may reflect an inflammatory response to the *Leishmania* protozoa.

None of the domesticated animals were found to have cutaneous leishmaniasis. We were unable to examine the hyraxes to find out if they were infected or not. This means that the cutaneous leishmaniasis in this area could be anthrophilic or zoonotic.

Conclusion

The survey confirmed the presence of cutaneous leishmaniasis in the Naivasha district in Kenya. More research on *Leishmania* species, hosts, appropriate treatment and prevention is required to control this disease.

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ONYALAI: a Neglected African Disease

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Abstract

Two patients with onyalai from the sugarcane-growing area of Nkhota Kota, Malawi, are reported.

Key words: onyalai, Malawi, haemorrhagic blister, thrombocytopenia, neglected tropical disease.

Case 1

A 16-year old boy presented with a 2-day history of oral and subconjunctival haemorrhagic mucosal blisters (Figs 1a, 1b and 2) and haemorrhagic blisters on the skin (Fig 3). Five days previously he had developed fever and generalised body pains and weakness and then the blisters had appeared.



Figs 1a and 1b. Case 1. Oral haemorrhagic blisters



Fig 2. Case 1. Subconjunctival haemorrhagic blisters



Fig 3. Case 1. Cutaneous haemorrhagic blister

Case 2

Two days later a 28-year old man presented with similar lesions in the mouth and bleeding from the nose (Fig 4).



Fig 4. Case 2. Nasal and oral haemorrhagic blisters.

Continued overleaf...

ONYALAI: a Neglected African Disease...continued

Investigations and Progress

On admission, their mean platelet count was $29 \times 10^9/l$ and the mean haemoglobin 9.6 g/dl. They were both HIV negative. The management consisted of the correction of blood loss and prednisolone. The response to treatment was so good that they were discharged within a week. Onyalai is a neglected tropical diagnosis which is distinguished from classical idiopathic thrombocytopenic purpura, a disease also encountered in Africa.

Discussion

“The presence of blood blisters on the tongue and oral mucosa of an African is strongly suggestive of onyalai” Jopling¹

Onyalai is an acquired form of immune thrombocytopenia which differs clinically, epidemiologically and immunologically from classic idiopathic thrombocytopenic purpura². The first case was reported in 1904 by Wellman². It has been reported among black populations in Central and Southern Africa^{2,3}. The affected age range is from less than a year to 70 years with a peak between 11 and 20 years old and seems not to be gender-specific². The exact cause is unknown. The consumption of tainted foods, however, has been suspected². Onyalai is an acute disease that is

characterized by the development of hemorrhagic blisters on oral, nasal and subconjunctival mucous membranes and skin, including on the soles of the feet. It is associated with thrombocytopenia and anaemia. Haemorrhage from ruptured bullae, epistaxis or gastrointestinal bleeding may be severe and cause shock and death^{2,3}. Treatment is directed at the prevention of haemorrhagic shock^{2,3,4}. Prednisolone, vincristine sulphate, splenectomy and intravenous gammaglobulin may be used in management of patients with this condition^{2,3,4,5,6}.

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INTERNATIONAL SERVICE PROJECT Mission Trip to Nigeria University of Mississippi Medical Centre

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The Department of Dermatology of the University of Mississippi Medical Center (UMMC) developed the Mississippi Nigeria Education and Mentoring Exchange (MNEME) to promote sustainable clinical, educational and research efforts in rural Nigeria. Maureen Offiah, MD, a chief resident in the Department of Dermatology organized the mission to Enugu State in Nigeria where she grew up. Dr Offiah spent the month of October, 2017 in Enugu State as an elective rotation while three faculty members (Robert Brodell, MD, Sabra Sullivan, MD and Jeremy Jackson, MD) rotated into Nigeria for one week each. Nigeria is the most populous country in Africa with over 184 million people. There are fewer than 130 dermatologists and only 2 fellowship-trained dermatopathologists practising in the country. The American Academy of Dermatology provided financial support for the mission and Direct Relief.com provided 800 pounds of medications.

The group recognises the importance of sustainability in medical mission efforts and hopes to repeat the trip in 2019.

The goals of the mission were fully achieved:

1. Nearly 1000 patients received medical/surgical dermatology care at Enugu State Teaching Hospital and outreach clinics in rural areas.
2. Several hundred medical students and resident physicians in Enugu were taught dermatology in the examination room and through a series of ten didactic lectures.
3. The team examined patients with advanced presentations of common diseases due to access to care issues and some conditions they had never before seen, such as monkey pox.
4. Two rural communities benefitted from medical outreach programs when the group worked in community health centres.

NATIONAL LEPROSY SYMPOSIUM 2018

Report prepared by: P Narasimha Rao, Santosh Rathod & Sujai Suneetha

A 'National Leprosy Symposium' on the theme of 'Accelerating towards a leprosy-free India' was held on the 24th of August, 2018 at Hotel Radisson, Kaushambi, Delhi NCR. The symposium was jointly organised by the **Indian Association of Dermatologists, Venereologists and Leprologists (IADVL)** and **Indian Association of Leprologists (IAL)**, with **IADVL - Special Interest Group (SIG) Leprosy** taking an active lead in organising the symposium. The symposium attempted to bring together as many key stakeholders in leprosy in the country as possible to discuss key issues of current therapeutic importance that could impact the National Leprosy Program and possibly arrive at a consensus statement/ guidelines for implementation.

A total of 52 representatives from 19 different national and international organisations/ groups participated in the symposium. These included representatives from the Central Leprosy Division (CLD), Government of India; National Leprosy Elimination Programme (NLEP); Representatives of the World Health Organisation (WHO) New Delhi; IAL; IADVL; IADVL Academy and 13 other key national and international stakeholders working in leprosy in India.

The symposium had three specific objectives with three strategic approaches of therapy, chemoprophylaxis and immunoprophylaxis. The focus was on discussing the efficacy, value, limitations, availability and administrative aspects of administration of: (1) **Uniform-Multidrug Therapy (U-MDT)**; (2) **Single Dose Rifampicin (SDR) as a chemoprophylaxis tool**; and (3) **MIP vaccine and other vaccines** in the **immunoprophylaxis** of leprosy.

The symposium was inaugurated by Dr. Ramesh Bhat, President of IADVL and Dr. Rathindra Nath Dutta, President of IAL who highlighted the need for cooperation among IADVL, IAL and all agencies working in leprosy to join hands and fulfill the goal of leprosy elimination and a leprosy-free India. Dr. P Narasimha Rao, President-Elect, IADVL, presented an overview of the goals, objectives and structure of the symposium which included a plenary talk on each of the topics, followed by 2-3 short perspectives on the issues and a panel discussion on the topic by a few experts with inputs from the floor. The summary of the discussions and conclusion reached on the three topics is outlined below.

Uniform Multidrug Therapy (U-MDT)

Dr. Kiran Katoch gave an overview of U-MDT. She presented data from the U-MDT study carried out in India and in other parts of the world. She mentioned that the inclusion of clofazamine as a third drug in PB leprosy patients resulted in better short- and long-term treatment outcomes; the beneficial effect in preventing type 1 reactions/neuritis; and that the side effect of pigmentation was reversible and short-lived. Dr. E. Cooreman, WHO representative, presented a WHO viewpoint on U-MDT. He mentioned that the GRADE method is used to develop new treatment guidelines for leprosy, which is evidence-based, transparent and public health oriented. He said that based on a grading of recommendations, assessment, development and evaluation, new WHO guidelines for treatment of leprosy were developed and approved in 2018 (http://www.searo.who.int/entity/global_leprosy_programme/

[approved-guidelines-leprosy-executives-summary.pdf](#)) which advocates a 3-drug regimen containing clofazamine for both PB and MB leprosy for 6 and 12 months, respectively.

During the panel discussion it was felt that IADVL will adhere to NLEP on the use of the mainline drugs but will design studies to examine other regimens and develop guidelines for difficult/ special situations in leprosy like relapse, drug resistance and high BI patients. In conclusion the participants agreed to the use of a uniform 3-drug regimen for both PB and MB leprosy, but for different durations of 6 and 12 months.

Single Dose Rifampicin (SDR) as post-exposure chemoprophylaxis

Dr. Hemanth K Kar presented an overview on Single Dose Rifampicin (SDR). He said that in a study conducted in Bangladesh a 57% decrease in incidence of leprosy was observed in the first year and it conferred protection from active leprosy for 2 years, beyond which it did not show significant benefit. In an Indonesian study where two doses of rifampicin were given at 3-months intervals to the whole population in an area, a 50% protection was observed for 2 years with no protection from the disease beyond 4-5 years. From these two studies it can be concluded that SDR could offer short-term protection from leprosy in contacts.

Dr. Anil Kumar, DDG leprosy, Government of India, gave an overview on 'Post exposure prophylaxis (SDR) under the NLEP'. He mentioned the use of SDR in 163 districts in the country where the Leprosy Case Detection Campaign (LCDC) was conducted in 2016 and the expected benefit in preventing leprosy in the contacts and interrupting transmission. He said that NLEP is considering widespread implementation of SDR as a prophylaxis tool in India.

During the open panel discussion a few concerns were raised about SDR – that it protects against only some forms of leprosy (PB leprosy); that it affords significant protection only for 2 years after which it has very little effect; that it may result in a delayed diagnosis of the disease; and that it could induce drug resistance. In view of this it was advocated that very stringent surveillance protocols and carefully planned outcome indicators should be used to generate data on the short- and long-term value of SDR strategy.

In conclusion the participants felt that SDR is a good public health intervention and has the potential to prevent leprosy in the contacts.

Immuno-prophylaxis

Dr. G Pran Talwar spoke on 'Immunoprophylaxis with *Mycobacterium indicus pranii* (MIP)' (formerly named *Mycobacterium w*), which is a nonpathogenic environmental mycobacterium. It is used as an immunomodulatory agent in leprosy patients as it induces lepromin conversion from negative to positive; faster bacterial & granuloma clearance; a reduction in lepra reactions; and quicker cure in slow responders. MIP has received approval from the Drug Controller General of India (DCGI) and internationally from the USFDA. Dr Talwar recommended its inclusion in the national strategy to address leprosy in India.

Continued overleaf...

NATIONAL LEPROSY SYMPOSIUM 2018...continued

Dr. Archana Singhal gave an overview of immunoprophylaxis in leprosy and described the various vaccines studied in leprosy, briefly outlining their role. She concluded that in view of the several advantages of MIP, the Government can adopt it as an **immunoprophylactic agent** in a well-defined high-risk group of close contacts of an index case. **Dr. Utpal Sengupta** presented a perspective on immunoprophylaxis and the value of a primary approach using vaccines to create active immunity in the population to prevent leprosy, over a secondary approach of treatment alone.

During the open panel discussion there was agreement that MIP vaccine has the potential to prevent future cases of leprosy as well as prevent disabilities due to leprosy. Issues of greater concern were regarding the availability and cost of the vaccine and these were discussed at length. Dr. Anil Kumar, DDGI,

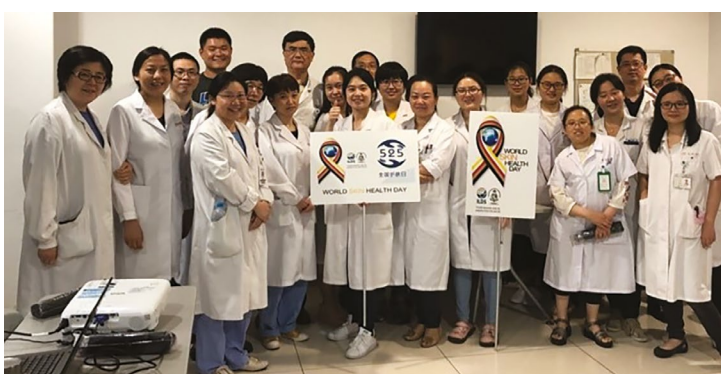
suggested its use initially in a 'blanket approach' in a pre-identified high endemic area of the country.

Other priorities identified

The participants felt that since all three interventions discussed have long-term outcome indicators of efficacy like relapse rates or occurrence of new cases, there is a need to identify short-term *in vitro* and *in vivo* biomarkers or clinical parameters to assess the efficacy of the interventions.

The need for IADVL, IAL and other NGOs to work in close partnership with the Government and with each other to support the strategy of the Government to tackle leprosy was stressed. One of the ways suggested was carrying out research studies to objectively and comprehensively establish the efficacy of these interventions.

World Skin Health Day 2018: Review



World Skin Health Day is a joint project of the International League of Dermatological Societies (ILDS) and the International Society of Dermatology (ISD), which aims to recognise and promote skin health around the world.

In 2018, we saw World Skin Health Day activities across the world; from Canada to Nepal via Nigeria and Brazil, to name but a few.

Clinics were a common activity and reached many people on the ground. Alongside this there were also social media campaigns and press releases, as well as awareness walks and educational workshops.



Skin cancer was a popular topic but there were also activities focused on Leprosy, Eczema, Vitiligo and Psoriasis.

Overall, we estimate that the 2018 World Skin Health Day campaign had a direct reach of over **89,000 people**. Nonetheless, challenges and gaps remain, particularly in terms of reaching underserved and underrepresented communities.



Please join us in recognising and promoting skin health around the world by taking part in World Skin Health Day 2019. To find out how and for more information, please visit <https://www.worldskinday.org/>

American Academy of Dermatology (AAD)

Meeting Registration Scholarship

(<https://www.aad.org/members/awards-grants-and-scholarships/aad-annual-meeting-scholarship>)

- Any country except USA/Canada
- 2 scholarships per country for board-certified dermatologists
- Complimentary registration & scholarship dinner & admission to half-day course at the annual AAD meeting
- Nomination comes from national dermatologic society
- Opens May 2019 for Denver meeting in 2020

Strauss and Katz World Congress Fund Scholarship

(<https://www.aad.org/members/awards-grants-and-scholarships/strauss-and-katz-scholarship>)

- Dermatology residents or dermatologists within 3 years of completing training at time of the meeting
- Resident of country with lower per capita GDP (website link has list of countries)
- Requires submission of an abstract & letter of endorsement by national dermatologic society
- \$1500-2000 USD stipend, depending upon travel costs
- Complimentary registration & scholarship dinner & admission to half-day course at the annual AAD meeting
- Opens May 2019 for Denver meeting in 2020

Women's Dermatological Society

(<https://www.womensderm.org/awards/award-programs/wds-aad-international-travel-award>)

- Women who are board-certified or board-eligible dermatologists and reside in a country other than the USA/Canada
- Up to \$2500 USD to be used to attend the WDS Annual Meeting Luncheon and the AAD annual meeting
- Requires letter of support from local, regional or national dermatologic society as well as proposed budget for travel, housing and tuition
- Preference to those with financial constraints and under the age of 40 years

International Society of Dermatology (ISD)

Global Education Awards

(<https://www.intsocderm.org/i4a/forms/index.cfm?id=50&widgetPreview=0>)

- Dermatologists and dermatology residents with preference for those less than 35 years of age at the time of the congress
- Up to \$1500 USD to be used to attend an ISD Regional meeting, Continental Congress, International Congress of Dermatology, or World Congress of Dermatology, depending upon the year
- Requires membership in the ISD; letter of support from Chair or Director of training program; and an abstract for presentation

Maria Duran Fellowship Awards

(<https://www.intsocderm.org/i4a/pages/index.cfm?pageid=3362>)

- Female dermatology residents or those within one year of completing training
- \$1000-\$2000 USD based upon number of awards (two vs one) to be used to attend an ISD Regional meeting, Continental Congress, International Congress of Dermatology, or World Congress of Dermatology, depending upon the year
- Requires letters of support from local, regional or national dermatologic society as well as Chair or Director of training program; age less than 35 years; an abstract for presentation; and proposed budget

If the applicant lives in a country without a national dermatology association, a regional or continental society can endorse a letter of recommendation from a local dermatologist

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Please send your submission by email to CSH@ILDS.org or by post to Community Skin Health, International Foundation for Dermatology, Willan House, 4 Fitzroy Square, London W1T 5HQ, UK

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The International Foundation for Dermatology (IFD) was created in 1987 to carry out the humanitarian work of the ILDS. Today, the IFD supports projects in Africa, Asia Pacific and South America. CSH is the official journal of the IFD.



Promoting global
Community Skin Health
through education