Dermatology Mondays: On a Global Scale

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"That's when I first learned that it wasn't enough to just do your job, you had to have an interest in it, even a passion for it." – Charles Bukowski

Each Monday, as physicians, we start our "working week". If one happens to live in Iran, the week begins on a Saturday. The actual day does not matter; the job we do is linked to humanity not chronology.

We examine our patients' lesions and occasionally palpate their skin; but first we listen to their stories. Based on our years of study and training, we seek information from what we hear and see. Sometimes we perform tests, but most of the information comes from the clinical examination. We contemplate, explain, counsel and recommend. Our job is to try to help all comers; and eventually we become part of their stories.

As a consequence of continuous changes in medicine, the practice of dermatology in the future is certain to be different from that of today. However, the lesions and the stories will remain the same. They are what drive the patients to seek our help, as has always been the case.

The practice of dermatology may also vary in different parts of the world, depending on the circumstances our patients' experiences, the environment, the genetics, the vagaries of the healthcare systems, or any of number of other factors. Thus, while we may think we are bound together by our specialty we may all in fact be doing different things. We may be as different as our patients.

We therefore decided to do something simple: we asked a group of colleagues who work in different parts of the world to collect the first 10 cases on a given Monday in their practices in order to gauge the dimensions of dermatology as it is practiced routinely. Not as big data, or formal epidemiological studies, but as the personal encounters that constitute the work we do. This gave us a "snapshot in time" of global dermatology.

Twelve colleagues from 12 countries participated (Fig. 1). The youngest was 36 years old and the oldest 73 years old, with a

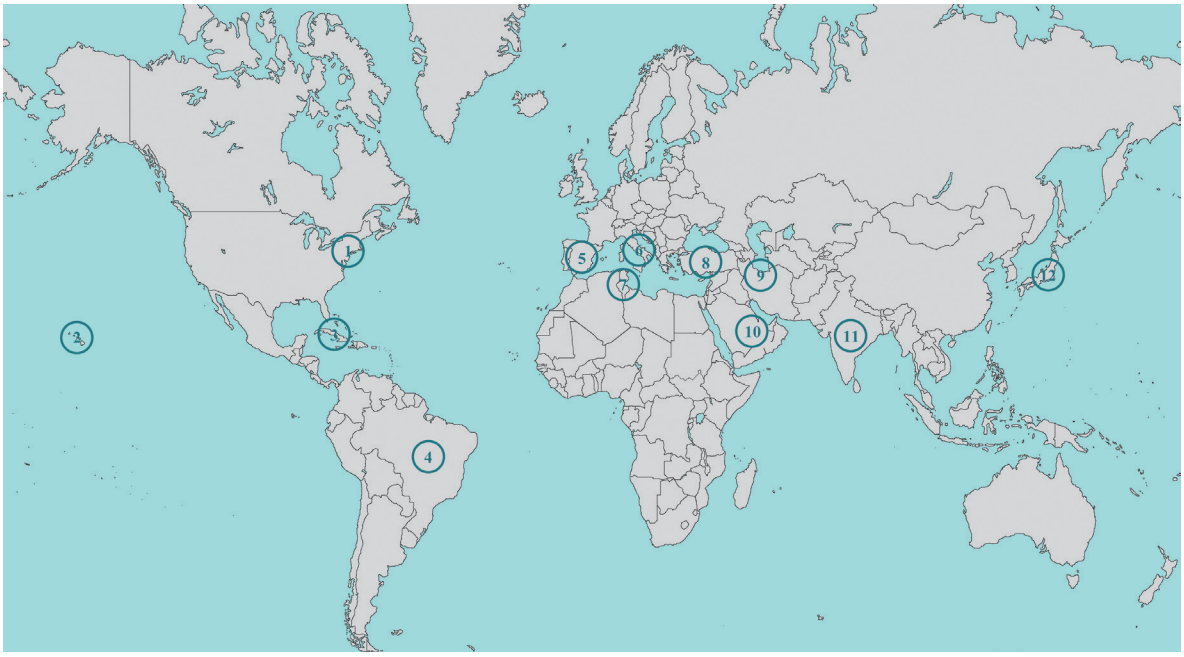

Fig. 1. Participating countries.

range of 6–36 years of experience. The diseases were as varied as those who treat them: cutaneous infections (22 patients) were the most prevalent skin diseases, most likely reflecting the special role of the skin as the interface between our bodies and the environment. It may be that our journals are full of papers on inflammatory disorders and cancer, but perhaps simple infections need to be re-evaluated from the perspective of global dermatology. In particular, fungal infections are most common infectious diseases.

Dermatitis ($n=16$), acne ($n=16$), psoriasis ($n=12$) and skin cancers ($n=7$) are among the common non-infectious skin conditions (Table I). While environmental influences may play a large role, these diseases predominantly show how our bodies react, and by doing so tell us about ourselves. We may not yet know the exact pathogenesis of psoriasis, but we do know that nail psoriasis is associated with enthesitis and psoriatic arthritis.

Certainly, neither this approach nor this small amount of data can be analysed statistically, but it gives us a glimpse of today's dermatology on an anecdotal, human scale and, even with this amount of data, important differences emerge. Dermatologists do not do the same things all over the world, although they all treat skin disease. It appears obvious that the environment; physical as well as psychological, social and economic influences their work. One would not expect less. Thus, while skin cancers are the main skin problem in the West, infectious diseases remain the main reason for referrals to dermatologists in less developed countries, reflecting the life-style and expectations of our patients.

In the globalized world of the Internet and easy communication this anecdotal approach could also be considered as a "mega-grand round". For instance, a patient from a Cuban dermatologist can be discussed by experts in the field.

> *Patient # 3* was an old patient of mine. About 3 years ago, in 2013 he was hospitalized and referred to me with pruritus, with oily and adherent scales, vesicular lesions on his scalp, shoulder blades, face and trunk. I did a biopsy which confirmed my diagnosis of pemphigus erythema-

Table I. *First 10 cases on a random Monday in 10 different countries*

					Country No.				
1	2	3	4	5	6	7	8	9	10
Erysipelas	SCC	Subcorneal pustular dermatosis	Tinea capitis	Common wart	MF	Herpes zoster	Insect bite	Atopic dermatitis	Vitiligo
AK	AK	Alopecia areata	Psoriasis	Hidradenitis suppurativa	Psoriasis	Eczema	Tinea capitis	Linear IgA dermatosis	Acne
Melanoma	Psoriasis	Pemphigus erytematosus	Hair shedding	Insect bites	AK	Hand eczema	Erisipelas	LP	Atopic dermatitis
Psoriasis	HSV	BCC	Seborrhoeic Dermatitis	Urticaria	BCC	Acne	Tinea versicolor	Dermatitis	Androgenetic alopecia
BCC	Guttate psoriasis	Tinea facialis (Incognito)	Vitiligo	Psoriasis	Keloid	Epidermoid cyst	Acne	Acne	Vitiligo
Acne	Psoriasis	Tinea pedis (moccasin)	Larva migrans	Acne	Vitiligo	Mollusca pendula	Oral aphthous	AGA	Acne
Psoriasis	AK	Seborrheic keratosis	Vitiligo	Seborrhoeic keratosis	Prurigo	Hand warts	Thrombo-phlebitis	Alopecia areata	Acne
Dermo-graphism	Psoriasis	Psoriasis palmar	Seborrhoeic dermatitis + Impetigo	Atopic dermatitis	Seborrhoeic dermatitis	Acne	Scleroderma	Acne	Skin tags
Psoriasis	AK	Acne	Malassezia folliculitis	Ingrown toenail	Naevi	Atopic dermatitis	Behcet's disease	Genital wart	Acne
Earlobe keloid	Atopic dermatitis	Wart	Tinea pedis	BCC	Acne	Onycho-mycosis	Molluscum contagiosum	LP	Tinea corporis

SCC: squamous cell carcinoma; AK: actinic keratosis; HSV: herpes simplex virus; BCC: basal cell carcinoma; MF: mycosis fungoides; LP: lichen planus; AGA: androgenic alopecia.

> tosus. I prescribed prednisone 60 mg for 2 months, until cessation of new blisters but I can't stop the treatment… never. Every time I try to discontinue the prednisone the blisters reappear. The minimal effective dose was 10 mg once a day from 15 months ago until today when the patient presented with a new lesion that started 8 days ago. I decide to increase the dose to 20 mg a day.

Elsewhere the dermatologist might consider treatment with methotrexate or rituximab, but the environment of where we practice shapes our work. Not only the patients' expectations and diseases are shaped, but also our traditions and opportunities. So, although we may have more in common than we think, important differences exist. These are sometimes regarded as obstacles, but in this wide world they are better seen as sources of inspiration, providing global opportunities on a humane scale.

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