THE GENERAL PRACTITIONER'S REQUIREMENTS FOR DERMATOLOGY *

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It is hard to understand why nobody at medical school advises students on what equipment will be needed in general practice. To decide this demands discrimination, experience, a constant association with the problems of practice, a clear idea of the frequency and importance of these problems, and a knowledge of local conditions. It is therefore not surprising that many academic teachers prefer silence to risking an answer on such a demanding topic. I expect many may disagree with my own views presented here, but it is luckily highly instructive to hear dissenting opinions.

The first essentials for a general practitioner who wants to help his skin patients are an interest in the subject and a good book to consult. A suitable book that is reliable and modern is the *Manual of Cutaneous Medicine* (Philadelphia: Saunders) written by Pillsbury, Shelley and Kligman. In England it costs £3 6s. 6d., to which must be added 20 or 30 cents for postage and insurance. The local price is higher. It is quite the best book I know for the practitioner, and can be recommended without reservation. First one needs to read this book right through once to know what is inside it; then one should return to the relevant parts of it as one's clinical problems demand.

In asking how the general practitioner should equip himself, let us first consider the instrumental aids to diagnosis and then the requirements for treatment.

Instrumental Diagnostic Aids

The first optical aid, and not a very important one, is a small 10× pocket-size magnifier. Many dermatologists prefer to fit themselves up with various sorts of eyeglasses. The effect produced depends on the model they choose. When seen in action they may remind one of anything from a picture of Franz Schubert to a charging rhinoceros. These visual aids are largely used to give them time to think, much like the physician's stethoscope. The only times I find a hand lens indispensable are when I want to pick a scabies mite from the burrow, to identify a nit or a louse, to examine scalp hair for damage or dystrophy, or to see if a small lesion (e.g. a plane wart) has a papillomatous surface. In addition needles will be required for digging out the scabies mite. For the hairs I prefer and recommend a fine-pointed splinter forceps in place of a proper epilating forceps.

The next essential is a microscope with low- and high-power lenses. An old-fashioned one will do perfectly well, although an expensive modern microscope is a delight to have. One needs the microscope to examine scrapings for fungi and to look at scabies and other parasites. It is helpful to show the living mite under the microscope to scabies patients. It makes them cooperate better in the treatment and drop all irrelevant talk of diet and acidity. When viewing such a demonstration, some patients regrettably still ask: 'But what causes it, doctor?' For the rest, every suspected case of fungous infection must be examined for the presence of organisms. Slides, coverslips and 30% potassium hydroxide in a dropper bottle are needed. Hairs can be pulled out with splinter forceps, blister roofs removed with a small curved scissors, and surface scrapings made with a *blunt* scalpel. How to prepare and examine the specimens so taken requires some practical experience which it is not my purpose to describe. My intention is simply to indicate what is required to achieve that experience.

This amount of amateur mycology is to my mind an essential. Mistakes are made by general practitioners every day for want of a simple diagnostic control. Griseofulvin is given for moniliasis, pityriasis versicolor is mistaken for vitiligo and even leprosy, eczemas are treated for non-existent fungous disease and so on. None of these mistakes is really justifiable, and they are avoidable at the first consultation.

What about allergy tests? I shall not say anything about scratch or intradermal tests, since they play a bigger role in other studies than dermatology. Dermatology is however the playground of the patch-tester for contact dermatitis. For the patches I can recommend the excellent squares with a ready-made lint pad called 'band-aids'. Having done my patch tests for two years with these band-aids without thinking the method particularly unusual, I saw a note in a journal in 1957 by a colleague in America saying how useful these band-aids actually were for patch tests. Liquids and moist solids can easily be placed on the pads, which are then applied to the skin for the usual 48-hour period. They stick well, even in the bath. If perforated, the patches must be sealed with sticky tape to prevent evaporation.

Laboratory Investigations

What use should be made of the pathologist for any diagnostic work on the skin? I believe the best procedure is the following. Formalin and bottles should always be handy at the place where any tissue is removed, and all abnormal tissue should be sent for microscopy. I make several exceptions, however. Obvious conditions, such as warts, sebaceous cysts, seborrhoeic keratoses, trivial solar keratoses and skin tags, need not usually be sent. Even these should be examined histologically if the patient would conceivably be pleased to have the laboratory check.

One gets a good service from the pathologist with tumours, though some pathologists are moved by an undue pessimism. This is based on caution, and cannot be helped as long as they are out of touch with the clinical side. When the lesion is not obviously a tumour, I believe that consultation and biopsy by a dermatologist is essential. The pathologist can seldom substitute for this, and his guesses sometimes cause unnecessary repercussions. There can be no more awesome team than a general practitioner and a surgeon, a radiotherapist or a pathologist trying to manage what might be a quite simple skin case. It leads at times to a veritable *folie à deux, à trois,* or as far as you need count in French to describe the situation.

Requirements for Treatment

In this country skin problems involve a great deal of minor surgery, almost all of which can be done under local anaesthesia in the consulting room. I have had no trouble with several thousand injections of 'xylocaine' and adrenaline from a dental cartridge syringe using a one-inch fine-gauge needle for *strictly intradermal* injections. The patient with a skin lesion never needs a nerve block or a subcutaneous injection, so the personal risks to him are virtually zero in the rooms, and considerably less than they are at the dentist or travelling in his motor car.

Many doctors feel that a shiny hot-water sterilizer that takes ages to boil is what all consulting rooms must have. While not advocating domestic furniture with immersion heater in its place, I have nevertheless had far more use out of an autoclave. 'Hibitane' solution can be used for storing the instruments, and a tiny fast-boiling immersion cooker, just big enough for a 5 ml. syringe, can be used for injections. With an autoclave a complete small surgical set, or indeed several of them, can be prepared, for use at a moment's notice. Sterile swabs and towels are always ready. Of course, many may allege that they have theatre facilities available, but it must not be forgotten how much time can be wasted if one depends on an outside organization for occasional help like this. Is there any alternative? In general practice I once worked for an ex-bacteriology lecturer who had buried himself in the country. This man assured me that cotton wool from the ordinary 'swiss-roll' packets was sterile enough, provided you wiped with a surface that had not been touching the blue paper. He may have been right, but one must add that his microscope was also permanently out of order. I pass on his opinion for those who feel prepared to accept it.

Assuming one is prepared for minor surgery in the rooms there is no doubt in my mind that every general practitioner

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should also have a high-frequency desiccator and learn its judicious use. Not only is it useful for warts, but I also believe that the man who is interested could with great advantage learn the appropriate techniques of dealing with the 'tamer' sorts of skin tumours. He will inevitably deprive the cancer quack, the surgeon or the radiotherapist of some sought-after business, but if the cases are suitably selected and controlled, he can do the public enormous good. He can be of greater value in the campaign against cancer than the present systematic scaring tactics so widespread among the medical and lay public alike.

One important therapeutic item remains, and that is freezing. Nowadays I use this only for sandworms, and then use only dry ice. If I had to choose between ethyl-chloride spraying and liquefied-phenol painting, I would prefer the phenol if dry ice was not available to produce the required epidermal death.

Dressings

To finish up, what dressings and therapeutic chemicals should one have handy? 'Elastoplast', 'kleenex' tissues, band-aid, carbonet, and occasionally viscopaste are needed. Beyond these, I always keep cotton buds, antibiotic surgical powder ('aureomycin'), 'sterispon' and 'nobecutane' (in a nail-polish bottle with brush, not in a jet can). Chemicals required are phenol, trichloracetic acid (with tooth picks for application) podophyllin suspension and hibitane solution. Their use, and the occasions where they are used, must be learned.

As regards instruments, the usual small surgical instruments are necessary, as well as a series of different-sized Volkmann's spoons, comedo extractors and No. 11 Bard-Parker blades.

Conclusion

To some people these requirements may seem too many, but I find it hard to imagine how one can get satisfaction from less if one sincerely wishes to come to grips with the management of skin problems in general practice. For those who prefer dermatological first-aid to proper dermatology there are others who can give them the advice they require.

In a recent survey, several journals that run an 'Any Questions' column found that over a quarter of the queries sent in are on dermatology. The need for improving a practitioner's dermatological skill obviously exists, and I have tried here to give part of the answer towards its fulfilment.

My last word would be this. Try calmly and quietly to find out what each skin case is all about. Do in fact what all mathematics teachers advise — have a good look at the problem first before deciding what sort of problem it really is and what approach to adopt. Then you can begin to look at it more as the cat looks at a mouse, instead of being forced to adopt the mouse's point of view, with its many disagreeable consequences.