History of Development of Dermatology in South Bucks
Dr D S Wilkinson, May 2009

Note: This is given more concisely in my Prosser White Oration published in Clinical and Experimental Dermatology 1986.11.1-16 but a rather fuller account is given here.

1. Nature of County: Buckinghamshire, a hilly and wooded county linking Oxford and London and a reputation in the past centuries of being the refuge of heretics, vagabonds and thieves but in recent times it has settled down to be a quiet, self-contained county with a stable and indigenous population, unchanged until the influx of immigrants and Londoners to industrial areas changed that towards the middle of the twentieth century.

The south, more active and industrialised, has High Wycombe as its chief town. This became a major centre for furniture and woodworking – the Windsor chair was made here in abundance - and in the Marsh, paper and stamp producing. Its only other distinction is that they weigh their mayor at the start and end of his tenure, I suppose to make sure that he has not fattened himself at their expense. To the north east of Wycombe lies the quieter towns of Beaconsfield and a few miles beyond that Amersham, (originally Amondesham after a Saxon mercenary) and its close relation Chesham on the Chess, noted for its watercress, butter pats and shoe making. To the west of Wycombe lies Stokenchurch at the edge of the escarpment and Princes Risborough nestled just below on the Vale of Aylesbury. To the east Buckinghamshire meets with Middlesex at Maidenhead and Uxbridge towards Taplow and Slough. To the north it impinges on Hertfordshire and Bedfordshire, the frontier towns of Tring and Berkhamsted. Apart from these the county is straddled as numerous villages, hills and dales. Among them Hampden, where Cromwell's cousin, John Hampden, objected to the King's tax and was thus partly responsible for the civil war in England.

Dermatology:

Up to the end of the second World War, consultants in all branches of medicine were normally only found in the big cities, London and Oxford for example. Occasionally, affluent patients might travel to London by stage coach or, later, railway to see one but this was rare and most cases were treated by local doctors, some of whom might have a particular experience or interest in one special branch of medicine or surgery. One remembers that shortly after the war there were three or four such doctors. They often worked some of their time in the local hospital. There were at that time two main hospitals in Bucks, The Royal Buckinghamshire Hospital in Aylesbury, partly designed by Florence Nightingale, a Verney, who lived her latter years in the north of the county. This was supplemented during the war by the larger, huted, Stoke Mandeville Hospital which gradually became the main hospital for the north part of the county. In the south, the smaller High Wycombe War Memorial Hospital (First World War) could only spread in a very few huts in the grounds in the middle of High Wycombe. In Amersham, the original poorhouse, a listed building, also developed into a large complex with huts in the grounds erected by the Canadians to be available for their wounded. It was here that dermatology as such began. There were two or three other small hospitals such as
Chesham and Chalfont St Peter but at this time they did not serve anything but local GP services.

However, during and for a while after the war a few physicians and surgeons came out from London to start clinics in Bucks. It was natural that most of these were from hospitals in the west of London such as St Mary’s and the Middlesex. But among them was a remarkable man Dr GB Dowling, whose aim was to disperse the team of young ex-servicemen who had gathered around him at St Thomas’s Hospital in consultant jobs in Dermatology throughout the south west of England.

**The early days of Dermatology:**

**First phase:**

Dr G B Dowling came to Amersham on a Saturday morning. A Dr Price was doing a similar fortnightly clinic at Aylesbury. Dr Dowling asked if I would come to assist him and although I lived in Letchworth, a number of miles to the north I jumped at the chance and would traverse the west of London to arrive at 9:30. We both worked in a large consulting room in an improvised outpatients centre in the grounds of the hospital. There were three small examination rooms and a larger adjacent room for dressings, biopsies, etc.

The clinic was usually fairly short and at about 11 o’clock G B D would leave me to do letters, biopsies, etc. and went to the medical superintendent’s office, then a Dr Lovelock Jones, FRCS, to see any private patients. At about 11:45 we would both leave the clinic and repair to The Crown in old Amersham for a half pint before he set off to Huntercombe to play golf with some Oxford pals.

A slight digression here; the history of Amersham Hospital is quite interesting. The main structure was a Poor Law House built by Gilbert Scott in flint and now a listed building. During the war the huts were erected, as I have said, and they remained like this until recent years when the site was completely re-built.

At Chalfonts, the small hospital was built by a group of GPs to provide for their own needs. Despite official disapproval it continued and more recently has been developed into a small efficient hospital, at least for outpatient use. In the north of the county where communications were less secure, hospitals were few and consultants almost non-existent, GPs went to extreme lengths to do all they could to alleviate the problems of their patients. I remember doing a domiciliary once in a remote village in North Bucks with a GP to see a woman with ? Paget's disease of the nipple. Instead of a biopsy to confirm it, the GP believed my diagnosis, opened his bag and proceeded to do a local mastectomy on the kitchen table. Such events were not rare. I should also mention the x-ray machines. In those days most dermatologists did have their own x-ray machine and used it for treating acne and similar conditions and occasionally for BCCs and so forth. I remember Dr Dowling had one in his office in London and so did I and I had one in my private rooms but we also installed one in the Amersham unit, monitored by a physicist.
who came down from Oxford. We found a dear lady, a Miss Peach, who we trained to look after it and this she did very efficiently but it was all a bit haphazard and these days it would be viewed by the health and safety authorities with the utmost disapproval.

After the creation of the NHS in 1949 an official post of, I think, four or five sessions was created and with G B Ds encouragement I applied. Apart from his testimonial I had also one from Dr A K - a colleague of war time days in the SOE - an unexpectedly good one I discovered later. It apparently clinched the matter and I was established.

The early need was to create a Dermatology Clinic at Wycombe, which for its far higher population had none. A room was found for me in a hut in the grounds close to Dr Barbara Wilkinson and her path lab. Intriguingly I had met her husband who was working in Cyprus during the war, so it was a curious coincidence.

Then, Dr Price's tenure at Aylesbury came to an end and I took over his fortnightly session, thus spreading from South to North Bucks. Soon these clinics were transferred to Stoke Mandeville and became more frequent. My own sessions increased accordingly, so I gave up my two sessions at St Peter's Hospital, Chertsey which I had been going since the war and before. These sessions in the north now included a fortnightly visit to Buckingham and Bletchley. A remarkable lady, of an old Bucks farming family, became my official hospital secretary. She was an appalling typist and her letters full of capitals, misprints and so on, have to be seen to be believed but they were works of art. She had remarkable charisma and took to dermatology to the extent that she had a sort of subsidiary clinic of her own in the typist's room after my own where she explained, I gather, what everything meant and what my diagnosis intended and so on.

But, with growing numbers and few facilities for inpatients either in the north or the south, the situation was becoming untenable and a new opportunity arose with the building of the large new Wycombe Hospital in 1956-1957. I submitted a plan for the half floor allotted for different specialties supplemented by a miniature brick model showing all the rooms and wards and space needed. This seemed to overwhelm the committee and the plan was passed almost without alterations. The area allowed for two wards of six each and two extra single rooms for isolation, a research room, a treatment room, a personal office, Sister's room and so on.

Our neighbour on the same floor, the third, was Esme Hadfield, an ENT surgeon, a delightful, eccentric companion who would often wander across to see what we were up to and tried to disrupt it. She became such a close friend that often when she wandered into South Bucks from her home the other side of Wycombe, she came to stay with us and when asked to sign the visitor's book she said ‘why should I sign this, I practically live here’. Her premature death in Oxford was a great loss to us. As my commitments in the South increased and with the opening of Wycombe Hospital a new consultant was appointed for the north, Margaret Walsh. One of our earliest registrars was Michael Waugh, later to be the leading expert in venereal diseases.
The approval of a specially designed unit, later generally known as "3B" was probably the first created in a provincial district hospital and allowed many innovative features and areas for research to be carried out. And we were not held back by the constraints of managers, officials, targets and so on. One could run one’s own department as one thought best and change whatever was necessary to keep abreast of the needs of the patients, who were then the only ultimate consideration. Much has changed since then. In all this, we were greatly supported by the regional hospital centre which stemmed out of the NHS organisation (but which was later dissolved, presumably to retain power centrally). We ourselves were particularly helped by two remarkably able doctors – Doctors Oddy and Dr (later Dame) Rosemary Rue. They evolved the idea of offering quasi-registrar positions to married women doctors not at present at work, with the prospect of advancing to full specialist status in time. In this way, we were able to recruit for our unit three invaluable helpers. These became part of the team and collaborated in several papers over the years, Doctors Kirton, Watts and Hambly. Dr Kirton, the longest of the three stayed on and developed a particular interest in Allergy, eventually becoming an official Allergist and practising this both in the NHS and privately at the Chiltern Hospital, Great Missenden.

The population of South Bucks, about 170,000 in 1947 grew to about 250,000 in two or three decades. We were seeing about 1% of the population a year i.e. in the region of 2000 new patients – 40 a week or about 15 patients a session; our total patient load was about 3.9 times this including the second subsequent visits which we usually wished to do for many diseases – notably eczema. This required 10-12 doctor/sessions, although there was always a problem acquiring enough staff qualified to do this in the four to five sessions accessible for outpatients. It should be said that it was a matter of routine that a waiting list should not build up: if necessary an extra session would be put in perhaps in the early evening, even if the all the other staff had left.

I had a system of going through all letters that were sent by GPs once or twice a week and sorting them out into what seemed to be urgent and separating these from the others, all were seen within two to three weeks except for those with warts that were deliberately given a longer wait as so many would, I know, fall off during this period. Pigmented lesions always worried me and I would see these quickly. In time a special "pigmented lesion session" was organised with access to a surgeon who was doing a clinic in the same hospital at the same time.

Another innovation was a short "newsletter" which Dr Kirton and I completed and sent to all general practitioners in the area. This set out our present interests and lines of research, to stimulate the flow of volunteers or referral of patients with a particular condition; and also some indication to the GP of a useful or newly developed treatment for their cases. It was I think useful for both parties and formed one of the threads of what was to become the concept of a "community dermatologist". This will be discussed a little later on.

With Dr Kirton’s help over 15 years we built up a substantial contact dermatitis/allergy clinic and from this grew an industrial clinic. The former was greatly enhanced by my
commitment at the time as a member of the ten strong International Contact and Dermatitis Research Group led by Niels Hjorth of Denmark requiring the results of patch tests often amounting to up to 200 from several centres, twice a year. This was invaluable in monitoring new allergens and the strength at which they should be used and at which they were reliable. It particularly applied to ingredients in new cosmetic substances widely available to the public. The Industrial Clinic grew partly out of this. Many unexplained rashes were increasingly seen in workers in local industries and from the very fortunate interest in dermatology shown by a local GP, Dr Michael Budden, who was also the Authorised Factory Doctor at that time. His open access to all the factories enabled us to establish the causes of several of these outbreaks and justified the creation of an industrial clinic which we held on Fridays, coincidental with the late reading of patch tests which might have been applied on the previous Monday. One very interesting outbreak in a small factory which threatened to disable some of the specialised workforce was traced to a particular West African mahogany, Khaya anthotheca, identified for us by the "Forest Products Research Laboratories", fortunately situated near the High Wycombe. This led to an interesting comparison with other forms of Khaya (see table).

Of wider significance was the identification of tetrachlorosalicylanilide (T4CS), then in a particular soap, as a photosensitising agent. The close and very helpful co-operation of the manufacturers led to a wide application of duplicate patch and photo patch tests, matching UVA-enhanced open and closed patch tests. The work of this clinic over 5 and then 10 years has been published (see appendix).

We were fortunate in working at a time when some new diseases were appearing on the scene and also being in a fairly well-contained and stable environment which I have likened to an island. The following can be given as examples:

"Perioral dermatitis". Previously described under various titles. We were able to observe it in a closed population and assess its yearly frequency. It peaked in 1972 and then declined. We felt that most, if not all cases, were caused by the application of strong steroids to the face. Dr Kirton found, curiously, that a course of antibiotics appeared to hasten cures. Another strange condition was "Black Heel" – an even more transient phenomenon affecting girls from a prominent local school at the end of summer in 1964. This was during a very dry season. The pigment, occasionally mistaken for melanin was, I was able to confirm, blood and, we believe, caused by shearing stress during games on a hard dry ground somewhat similar to "forefoot dermatitis", which appeared in 1968 and which we thought was due to a frictional effect in young people wearing occlusive plastic shoes. It disappeared soon after puberty. Another curious phenomenon perhaps also related to the Chiltern plateau and horse-riding country was a diffuse chilblain-like erythrocyanosis of the thighs in plump young women or grooms often wearing tight jodhpurs which we called 'Chiltern Chaps' or 'Bucks Bottom'. Forty years later I was approached in regard to a similar condition apparently found in Arctic sledgers.

"Subcorneal pustular dermatosis" posed a quite different problem. During the same period Ian Sneddon in Sheffield had also been seeing a rather unusual pustular rash
simulating (and thought by many) to be a form of pustular psoriasis but we found that the histological changes, particularly of early biopsies, was quite different and almost diagnostic. A fragile plant, it has not altogether successfully survived transposition to some foreign soils. Later, nine cases were found to be associated with IgA paraproteinaemia.

Finally, the rash occurring with the glucagonoma syndrome, a puzzling entity. Our own case, was to some extent unique in that with our adequate inpatient facilities we were able to follow the patient up for five years, taking her in to the ward from time to time; and eventually even to post mortem studies of the lesions.

A single dermatological unit serving a well defined population can play a useful role in monitoring new consumer products, especially in the cosmetic and toiletry fields. Following the T4CS outbreak we were asked to monitor a "pilot introduction" of a new soap with related but non-photosensitising material. We notified local GPs in our newsletter and added a question in our patient questionnaire, a form which we handed out to all new patients waiting and containing information that they provided about their suspected allergies, uses of soap and so forth. Fortunately no problem was encountered and the soap was generally released and proved popular. A similar exercise took place with a new toothpaste, here we also alerted local dentists, a few, but only a very few adverse reactions occurred.

But there are hidden snags and things do not always go as planned. Such a one occurred in a two-centre study of a new quaternary ammonium application for infected conditions. In a short trial on 254 patients it appeared to be well-tolerated but then we began to see cases of a necrotising balanitis in males. A chance remark of a colleague gave the answer. We had not tested it in occluded sites. The sin of omission.

Within our boundaries, North and South Bucks were distinct enough for us to be able to compare statistical information on diseases such as scabies, sexually transmitted diseases (since we were also in charge of VD clinics in the area), molluscum contagiosum, of which we had a minor epidemic – was it clustered or random? etc. But the fallacy of statistics drawn from hospital experience was limited, if not erroneous. We tested this out on erythema nodosum, a condition usually recognised by the GPs and thus not often referred to hospital so hospitals’ statistics in this case could have been quite fallacious and indeed were. To test this out we set up a two-year survey involving GP-only cases, hospital cases and the path labs to try to identify causes. This was a very fruitful exercise. It showed that the true incidence was far greater than that quoted in our own hospital figures and those from other areas. An earlier series examined in 1957 showed tuberculosis to account for 5.5% of the cases. In this survey we became aware of the role of Pasteurella pseudotuberculosis, but in only two cases. Intradermal tests of the Pasteur Institute antigen did not give high results such as those noted in France and Finland. An interesting study, the result of which were given in a talk at the RSM but never published.

The planned fourteen-bed unit at Wycombe enabled some innovations to be carried out in inpatient care, for instance, we tried taking in "weekend-break days" for over-anxious,
harassed eczema patients or those who cared for them; then during the week the bed might be filled by those requiring active therapy such as psoriatics having PUVA treatment or patients with leg ulcers. This last group were a particular problem and therefore the cause of a special study and regime.

Throughout South Bucks there was abundance of women with leg ulcers. A forgotten and neglected group owned by no one and with District Nurses not trained and often hurried providing for the most part quite inadequate dressings. Many of the patients were obese and had had venous thrombosis; in others arterial insufficiency was important. Sometimes both factors were present. These were the most difficult problem. Seeing them occasionally in domiciliary visits was salutary and helpful. Living often on cakes and tea and indolent from difficulty in walking, the rags of their dressings often hanging in the kitchens (Philoctetes was abandoned en route to Troy because of the stench of his foot ulcer). These patients obviously needed a much more vigorous approach. As inpatients they could have a better diet, leg elevation on special day beds which we obtained and a system of measurement of the extent of the ulcer and trials of a variety of treatments. One of these, the so called "Samaritan mixture" evolved on a domiciliary visit and was made from oil and vinegar obtained from the kitchen cupboard, perhaps a trial of honey, silver salts and ultimately maggot therapy – tolerated well by the ulcer but not very well by the patient. But above all the application of proper gradient pressure bandaging. None of this would have been possible except for our remarkable Sister and a team of very loyal nurses who often stayed with us for many years. The Sister was an old-fashioned authoritarian in a way but in another, she was the epitome of the old world Sister of bygone days. With her leadership, she and her nurses provided a wonderful team. Leg ulcer bandaging was carried out as demonstrations on the ward and subsequently, weekly or fortnightly, in the outpatient department after discharge. Success was gratifying but, in hindsight, we were remiss in not training more district nurses in the techniques of satisfactory leg bandaging. But we had the great help of Seton and others in the design and manufacture of suitable bandaging, including the useful Tubigrip.

Out of these projects developed the concept of the "community dermatologist", a person intimately concerned with all stages of those with skin disease in a well-defined area. The idea has been resurrected again recently but the difficulties in implementing it is considerable - bureaucracy, government policy, finance, etc.

Finally, the wealth of clinical material that was present in this area prompted regular visits from students from St. Thomas’s and St John’s Hospital for skin diseases. Some afterwards returned to spend more time in the department and so by a happy choice we had a succession of very able "registrars/assistant consultant" status doctors from Australia who re-enforced our establishment to everyone’s advantage. And so this phase came to an end, I retired and another dermatologist took over.