

# Who should look after genital skin disease in the 21<sup>st</sup> century?

**James Leveson, King's College London School of Medicine**

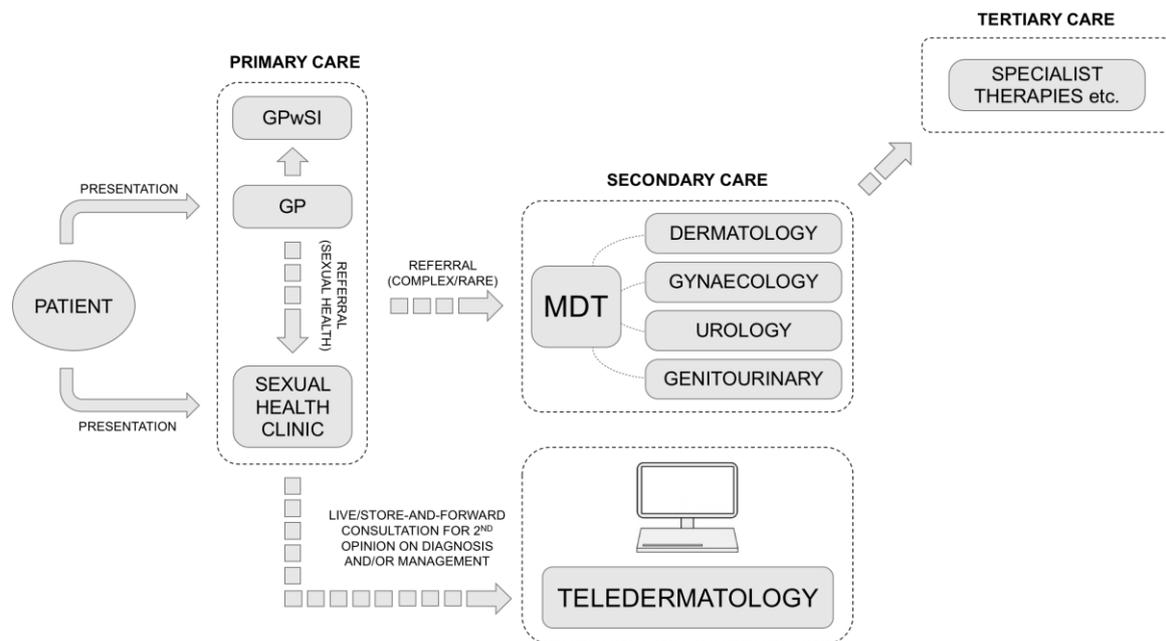
## **Synopsis**

Over the past few decades, there has been a shift in how we deliver healthcare to our patients. The factors underlying this shift are complex and inter-linking. Importantly, demographics have shifted the pattern of disease, new technologies have changed the way we deliver care and, crucially, patient autonomy and empowerment have led to a change in our role as doctors. In this essay, I provide an overview of one such group of patients and their journey through our ever-changing healthcare system – those with genital skin disease (GSD).

A wide range of infectious, inflammatory and neoplastic disorders affect genital skin. Some conditions are specific to the genitals (e.g. lichen sclerosus), whilst other 'genital manifestations of cutaneous disease' affect genital skin in a unique way (e.g. eczema or psoriasis) [1, 2]. Many specialties could be referred patients with GSD for diagnosis and management, reflecting the wide range of aetiologies of these conditions. The list is long – dermatology, gynaecology, urology and genitourinary medicine – and there is a lack of clear guidance as to who should manage what.

This essay focuses on several approaches to the diagnosis and management of genital skin disease. The majority of patients with GSD will be diagnosed and managed in either a general practice or genitourinary medicine setting. In general practice, there

is a need to improve the quality of care that patients receive. Due to a lack of human resource, it is unrealistic to manage all GSD patients in a genitourinary medicine setting. The most successful examples of complex and rare genital skin diseases are successfully managed in a secondary care, multidisciplinary team setting, but these services are not equally distributed around the country.



**Figure 1:** Proposed model for the uniform management of GSD in the UK

Crucially, a balance needs to be established between easily-accessible primary care doctors and the quality of diagnosis and management provided by specialists. The above diagram (**Figure 1**) aims to illustrate a potential model for the management of GSD in the UK. Teledermatology, which has been extensively regarded as an organizational solution in the literature, may represent a platform which addresses the issues set out above. The teledermatology model keeps patients in primary care and allows quick access to specialist review. It may also have the added benefit of identifying the most complex or rare cases earlier for in-hospital multidisciplinary management, avoiding unnecessary referrals.

Teledermatology is the application of telemedicine, the delivery of healthcare by use of information and communication technology, in the field of dermatology. Where it is available, a GP has the opportunity to consult a dermatologist for a second opinion *via* the internet in order to prevent a face-to-face referral. Teledermatology may be conducted by 'store-and-forward' methods, where transmitted digital images are submitted with a clinical history, or in real-time with videoconferencing equipment.

More research needs to be conducted to establish whether teledermatology can be applied to genital skin disease specifically. With advanced technology readily available in the 21<sup>st</sup> century, the only limiting factor of nationwide service provision in teledermatology may be cost. With the shifting services from secondary care into community settings, however, this may represent the most cost effective and reliable method of accessing expert advice quickly and effectively, thus maintaining high standards of quality in healthcare.

**Word count:** 604

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