

British Association of Dermatologists – Summer Elective Prize

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I am delighted to have been awarded a British Association of Dermatologists' Elective Project Prize.

With the support of this grant, I was able to gain an invaluable experience of Dermatology in Sarawak General Hospital, Malaysia.

Here, I hope to share why I believe that my elective in Malaysia was a formative experience in 3 sections: 1) clinical experience, 2) research experience and 3) enhancing my own practice.

Clinical Experience:

The range of diseases in Malaysia is different to that in the UK, such that the differentials for a clinical sign differ. Dr Pubulan Muniandy (Head of Dermatology at Sarawak General Hospital) called all his juniors into his office and asked for the

differential for bilateral tender red nodules on the shins of a 29 year old woman. “Ah- this must be erythema nodosum” I thought... Indeed this was the case; however, Dr Muniandy proceeded to ask what my differentials were. From my Finals knowledge I mentioned inflammatory bowel disease (ulcerative colitis and Crohns), the oral contraceptive pill and TB as my top three. Dr Muniandy smiled, it was a very British answer he said! In the Sarawakian population, inflammatory bowel disease was incredibly rare, and more common causes for erythema nodosum would be TB, sarcoid, Behcets disease and possibly even leprosy! This was a lesson that in dissimilar population groups physicians must think of a different range of diseases.

Furthermore, three patient cases stood out in particular for me. First, was a 79 year old gentleman in end-stage renal failure. He presented with all the features of his disease, tiredness from anaemia, pedal oedema, breathlessness due to pulmonary oedema, itching from phosphate retention and nausea. He also had an itchy red plaque on his back at the level of T12. On biopsy, it was shown that this was a cutaneous T cell lymphoma, a rare cancer occurring typically in the immunocompromised, in which T cells migrating to the skin cause lesions to appear. Second, I met with a 13 year old girl with an oval red ring-like patch on her left cheek. As a teenager beginning to consider her appearance, she was rather affected by this blemish. The diagnosis was clinched through looking at her toenails, they were severely hyperkeratotic and yellow. This was a case of tinea faciei, fungal infection of the face originating at the toenails (tinea unguium). Thirdly, I met a 52 year old man presenting with abdominal pain on eating (mesenteric ischaemia), 4 stone weight loss in 4 months and aching knees wrists. He had purplish hue to the skin over his shins, which was mottled and resembled a pattern of vessels. In fact, this was livedo reticularis, a cutaneous consequence of polyarteritis nodosa that this man suffered from. These three examples are among many cases I saw that I had never seen in the UK – I hope the broadening of experience in this way will allow me to diagnose these conditions when I see them during my own career in the UK.

Research experience

During my placement at Sarawak General Hospital, I also gathered data about the pattern of allergic contact dermatitis (ACD) in a subset of patients. Initially, I looked through the register of procedures in the Clinic, from which I recorded the names of all those who had been patch tested in 2013-2015. The paper records of all of these people were then extracted from the store. From the paper notes, I entered onto Excel demographics of the patient (age and gender), the area which was affected by the allergic contact dermatitis and the result of the patch test. The result of the patch test was recorded as the negativity (0) or positivity (1,2,3) of reaction to each of the 26 reagents in the European Standard Series at day 3 and day 5 after application of the patches.

I hope to process this data, considering the following questions: 1) commonest allergens causing ACD at day 3 and day 5, 2) frequency of allergens causing ACD in men/women and 3) frequency of allergens causing ACD in different body areas (e.g. face, limbs, trunk). Based on the results derived from the aforementioned, I will draw conclusions about ACD in the group of Sarawakian patients studied with the aim of publishing the findings.

Enhancing my own practice

There are certain lessons that I have learnt from my elective in Malaysia that I would like to take forward for my own medical career.

Whilst in a Clinic, a very slim 64 year old farmer presented with multiple clusters of pink papules in his groin which also followed the lines where they had been scratched (koebnerisation). He was very embarrassed by this. As the elder of his family and a respected member of his Iban tribe, admitting something was wrong with him was a dent on his pride. This rash was molluscum contagiosum, which can be a sign of underlying HIV infection. As the history emerged, this patient admitted that he was gay and was paying for sex (unprotected), but that this was something that he had hidden from his wife and family for years. This reinforced the importance of

considering the *person* who lives with the disease; indeed, the complexities in dissecting an accurate history and maintaining confidentiality.

In Sarawak, the structure of the Dermatology services is through 3 systems that feed into tertiary care. First, general practitioners will refer patients to tertiary care in hospital if further investigation and treatment is necessary. However, GPs in Sarawak cost a fee hence for some they are unobtainable. Instead, patients can use polyclinics which are free and occur once/twice weekly in the community. Polyclinics are led by dermatology registrars who triage patients providing a second stream of patients into tertiary care based on clinical need. Thirdly, consultants/registrars travel to the more rural areas of Sarawak for a few days each month to do outreach clinics for tribal people who may not have access to skin care otherwise. If there is sufficient clinical need, patients from outreach clinic will be referred to the hospital in Sarawak although efforts are aimed toward managing conditions in the community as attending appointments and follow-up is impeded by the distance and financial constraints tribesmen face. I feel that the concept polyclinics and GPs feeding into tertiary care in Malaysia are analogous to the role of GPs, GPSIs (GPs with special interest in dermatology) and dermatologist-led community clinics in the UK. I feel that triaging patients for tertiary care in this way is an effective system to preserve limited resources in healthcare systems.

Finally, I was lucky enough to receive teaching from Consultants and Registrars in Sarawak General Hospital. I completed several punch biopsies and cryotherapy for genital warts; these procedural skills will put me in good stead for the future. The teaching that I experienced enhanced my knowledge and skill; in return, when I am a trained clinician I hope to also teach my juniors to further their skills. The role of the clinical teacher in inspiring the future generation of doctors, I have learnt, is invaluable.

The skin is a fantastic – the first thing the eye notices and a window to systemic disease – I hope to continue developing my knowledge of this subject.