ELECTIVE (SSC5c) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

1. The greatest difference in skin disease in Sri Lanka compared to the UK is that there is a greater number of skin manifestations of systemic disease and tropical illness' in Sri Lanka. In the UK, my experience of viral exanthems/maculopapular rashes was rather limited - largely due to the MMR vaccination and the rarity of tropical infectious diseases. In Sri Lanka, tropical diseases are common and therefore firstly identifying a maculopapular rash and secondly its pattern and distribution, is an important skill to have. I saw many cases of dengue fever and a few cases of typhus and therefore was able to appreciate a difference in their respective distributions - a person with dengue may have flushed skin in the early course of the illness and then have a measles-like rash over the trunk after about 5 days - whereas a patient with typhus will typically have a blanching-like rash affecting the palms.

I have also seen a greater proportion of patients with skin manifestations of systemic disease. For example, it seems that a greater proportion of the population have nail changes such as clubbing. This may be because there is a greater proportion of liver disease and lung disease in Sri Lanka than compared to the UK. Terry's nails, something I had only seen once in the UK is something I see on a daily basis in Sri Lanka. Signs of high cholesterol seem to be more prevalent - such as xanthlasma and corneal arcus.

I also saw a gentleman with severe psoriasis, covering his arms, trunk and scalp. He had not been taking the treatment and he had not atteneded the clinic. He was from a poor background and from a more rural area, where perhaps the medical services are more limited. Although compliance to medication and attendance to services is a problem in the UK, access to medical servces in more rural areas and not being able to afford the treatment is not really a problem.

Overall, the common skin diseases in the UK seem to be just as common in Sri Lanka - such as acne in the younger population, psoriasis and eczema. However, because a greater proportion of the population have systemic illness' such as liver disease, early-onset type 2 diabetes and tropical diseases, manifestations of these in the skin is far more common. On the other hand, on a basic observational level, less patients had naevi or signs of sun damage such as actinic keratosis.

2. Unfortunately I was not able to observe the dermatology services in Sri Lanka because Peradeniya Hospital does not have a dermatology unit. I do understand that there is a dermatology unit and clinic at Kandy Hospital, which the doctors at Peradeniya can refer to if need be. I saw a couple of cases which required a dermatological opinion. An elderly lady presented with a widespread nodular-like rash across her trunk, arms and legs and also affecting the mucus membranes of her mouth. The rash seemed to occur after she commenced an antiepileptic and the working diagnosis of Steven-Johnson syndrome was made. As there is no dermatology unit at Peradeniya, it was organised fpr her to be transferred to Kandy hospital. Obviously, before her transfer she recieved supportive care at Peradeniya first. Another patient I saw presented with a long standing history of tightening of the skin around her mouth, a discoid rash behind her ears and cold extremities, with a gangrenous finger. She is thought to have a connective tissue disorder such as scleroderma or perhaps a mixed connective tissue disorder with systemic lupus erythematosus. She was referred to the dermatology clinic at Kandy.

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3. I had no first-hand experience of community medicine in Sri Lanka because I did all my work on two hospital wards. However, at Peradeniya hospital there is a preliminary care unit, which patients are referred to from various clinics, either at the hospital or from the community. At this unit, patients are then triaged either to the surgical ward or the medical ward. This triaging system obviously helps in that it enables patients to be in the right place, and it also keeps patients out of hospital if they don't need admitting. However, like the UK, there is a serious problem with bed shortage on the wards in Sri Lanka.

Disease prevention, both primary and secondary, is also very much in place in Sri Lanka. Many patients are taking anti-hypertensives and/or statins and there are specialist INR clinics for patients on warfarin. Common diseases such as heart disease and lung disease are clearly managed in a community setting, similar to that of the UK.

I have also observed that many patients keep a special book as a log for their care. For example, if a patient has to attend a clinic for a particular reason, the doctor will write in the book. I noticed many patients had these books with them on the ward. This method clearly helps with the continuity of care and services.

4. I think I have achieved my overall goals on this elective. The general ward is a great place to learn the basic skills I acquired as a medical student. A key difference between Sri Lanka and the UK is that doctors do not rely as much on investigations in Sri Lanka. Often patients cannot afford the more expensive tests, which leaves it down to the doctor to reach a diagnosis through the art of the history and examination. Although my ability to take a history was rather limited by the fact that there was often a communication barrier, I was able to hone my examination skills. For example, many patients had hepato/splenomegaly, so I was able get more confident at palpating a liver edge. Many patients had murmers to hear and for the first time I was able to auscultate a diastolic murmer due to mitral stenosis. Interpreting imaging films is a key skill because Sri Lankan doctors do not rely on a radiology report, so I made it my business to look at as many radiographs as possible.

I have had some experience of dermatology with patients of darker skin types due to the large Bangladeshi population in east London. But obviously all the patients I saw in Sri Lanka had darker skin, which made dermatology more challenging for me but yet was an important learning experience.

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