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Elective report 2014

ELECTIVE REPORT

DESCRIBE THE PATTERN OF DISEASE/ILLNESS OF INTEREST IN THE POPULATION WITH WHICH YOU HAVE WORKED AND DISCUSS THIS IN THE CONTEXT OF GLOBAL HEALTH

I undertook my elective placement in the Middle East, in both Sharjah and within Central Dubai. We chose to split our time between two clinics, in Sharjah our placement was in a community dermatology clinic where we attended both out of hours and general dermatology clinics. Our placement in central Dubai was at Dermacare skin centre, which was a skin cancer specialist centre, which also offered cosmetic procedures including botox, fillers, pigmentation correction etc.

The decision to split our elective placements between two different areas and types of clinics allowed us to get a much a better exposure of dermatology, we were able to see a wider range of conditions and we were also able to appreciate the difference between dermatological complaints in both centres. The community clinics in Sharjah were attended mainly by native emirates, who were only able to speak Arabic, this was a stark contrast to our experience in central Dubai where we mainly dealt with ex-pats, who were able to communicate in English. Although we were unable to take histories during the community clinics due to the language barrier, we were still able to examine the patients and help devise a management plan.

The main conditions we saw within the community and out of hour's clinics were different types of dermatitis, our dermatology consultant explained that it was the most common complaint that patients presented with. This was evident during our time at the clinic, the types of dermatitis ranged from atopic dermatitis, which is commonly seen in the UK and something that i had been exposed to during my placement within medical school, to photosensitive dermatitis, which is extremely rare in the UK but not an odd occurrence in the middle east due to the intense exposure to UV light.

We were able to see another huge aspect of dermatology whilst within Dubai which was the cosmetic side. It was extremely common for patients to present to their dermatologist asking for aesthetic procedures such as botox, lip fillers, face mask treatments and pigmentation treatments amongst others. Such procedures were extremely common and almost the norm, this highlighted to us the importance that physical appearance played amongst the population.

DESCRIBE THE PATTERN OF HEALTH PROVISION IN RELATION TO THE COUNTRY IN WHICH YOU HAVE WORKED AND CONTRAST THIS WITH OTHER COUNTRIES, OR WITH THE UK

The health care system within Dubai varied hugely compared to the UK. There was no national health service and it was largely private. General practitioners were also not prevalent within the Middle East, although they existed, they were often found within hospitals, where dermatologists also worked, as a result of patients having to pay for their treatment, they more often than not chose to see a dermatologist straight away rather than a GP, in a way cutting out the 'middle man'. After speaking to a number of patients at the clinic, it appeared to be a common misconception amongst the population that they would receive better care for a dermatological complaint from a dermatologist rather than a GP. Patients seemed to be unaware that minor

dermatological complaints such as mild atopic dermatitis could be dealt equally as well by a general practitioner.

General practitioners appeared to be underappreciated within the Middle East and as a result of few people using their services, few of them existed. General practitioners within the UK in contrast are the first port of call and are often the doctors seen by the majority of the population, referrals to specialists are done on an individual basis, with most patients not requiring a referral as their complaints can be dealt with in primary care. We saw many cases that I felt could have been dealt with by a GP which would have allowed patients with more serious complaints to see a dermatologist.

As patients were paying privately for their care, they had certain expectations of the type of treatment that they preferred to receive. For example, we saw a case where a lady presented with a 6 month history of numerous nodules on her sternum, that were diagnosed as being molluscum contagiosum, which is a virally driven dermatological condition which usually self resolves, however when this was explained to the patient she insisted on having the lesions removed. Although this is something which would also have been removed if the patient had insisted in the UK, it seemed that patients felt that as they were paying for their treatment that they were entitled to have something done, and they were not happy to be told that it would resolve on its own.

What are the prevalent dermatological conditions in Dubai? How do their differ from the UK?

As we were based between two very different types of clinics, the prevalence in each as a result was also very different. In Sharjah at the community clinic the most prevalent conditions were various forms of dermatitis, amongst the local emirates. Whereas in Central Dubai in the Dermacare skin centre, which specialised in skin cancer, the majority of patients attending were not locals and hence the most prevalent condition we saw was skin cancer. The rate of skin cancer amongst the locals was extremely low; our consultant informed us that he had only seen 2 cases of skin cancer since 1989, which highlighted to us that in fact it was very rare amongst locals!

During my dermatology placement in the UK, I saw a very wide range of conditions, including dermatitis, but the majority of dermatological cases I saw were those related to cumulative UV exposure in Caucasians, examples including actinic keratosis, basal cell carcinoma amongst other skin malignancies. These did not appear to be prevalent amongst the locals in the Middle East, however they were seen in those patients who originated from other areas abroad such as the UK and had settled in Dubai. So although there were differences in presentation of dermatological conditions, there were also many similarities.

How are dermatological services organized and delivered? How does it differ from the UK?

Dermatological services are offered in the form of independent clinics, both extremely private and community clinics, as well as dermatological services within a hospital. This differs from the UK, where although there are independent private dermatological clinics, they are not the first port of call for patients seeking care. I also found that when prescribing, the dermatology consultants did not refer to clinical guidelines to seek advice about which medications they should prescribe,

whereas in the UK, GP use NICE guidance to decide which treatments to prescribe and when they should refer a patient for more specialist care.