Cutaneous Manifestations in Rural Population

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Introduction

India is the second most populous country of the world and has changing socio-political demographic and morbidity patterns that have been drawing global attention in recent year. [1]

The health status of Indians is still a cause for grave concern, especially that of the rural population. About 75% of health infrastructure medical man power and other health resources are concentrated in urban areas where 27% of the population live. [1]

The rural population work in the most hazardous atmosphere and live in abysmall living conditions, unclean water, poor nutrition, Sub-human habitats and degraded and unsanitary environments are challenges to the public health system. [1]

Disease pattern in a given population is generally determined by different ecology. [3] In india there is a significant incidence of infections disorders because of under developed economy & social backward class. [3]

Skin disease is common in rural communities[2] and can have a profound effect on both the individual and the community. [2]

The prevalence of skin disease was 34.71 with most of the diseases being both treatable & preventable. [2]

Health Practices and Problems in Rural India

Rural people in india in general, and tribal populations in particular, have their own beliefs and practices regarding health. Some tribal groups still believe that a disease is always caused by hostile spirits or by the breach of some taboo, they therefore seek remedies through magicoreligious practices on the other hand, some rural people have continued to follow rich undocumented, traditional medicines systems, in addition to the recognised cultural systems of medicine such Ayurveda, Unani, Siddha and Naturopathy, to maintain positive health and to prevent disease. However the socio economic, cultural and political onslaught arising partly from the erratic exploitation of human and material resources, have endangered the naturally health environment.[1]

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Even today, the majority of Indians live in villages (72.21) where there is a rigid hierarchy and caste structure moulded by traditions and long standing customs. People mainly depend upon agriculture for their livelihood. There is a scarcity of essential goods, education, medical facilities and entertainment. There is also isolation due to poor communication and transport facilities. There is by and large, lack of adequate electricity, water supply and sanitation facilities. [9]

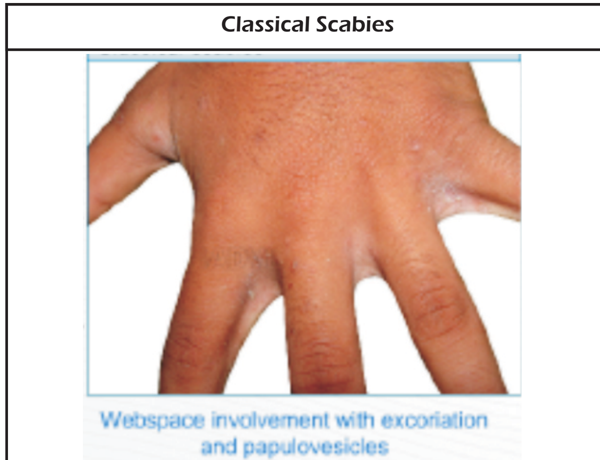
The early morning rituals of defecation and urination are still done in open fields using collected rain water or pond water for cleaning. This increase the number of flies and other insects, causing an abundance of pyodermas, zoonotic diseases and soil transmitted helmintic diseases.

Pattern of Skin Diseases in India

In 1960, Desai observed that 50% of Skin OPD consisted of Infectious which are normally recurrent scabies, pyodermas, superficial fungal infections, Pediculosis, Viral infections and were diseases of a poor economy.[4] In many parts of India the pattern of skin diseases is still & consequence of poverty, malnutrition, over crowding , poor hygenic, illiteracy and social backwardness[9] factors like education, improved

hygiene and sanitation, eradication of vectors of disease, improved nutrition and immunity depend upon an improved economic condition, whose role in determining the pattern of skin disease can be observed by comparing the patterns in rural and urban population.

Classical Scabies

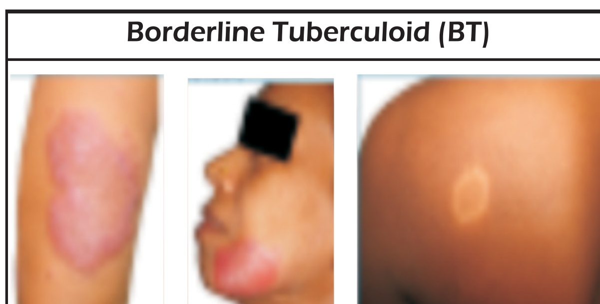

Webspace involvement with excoriation and papulovesicles

Bacterial & Mycobacterial Infection

The incidence of pyodermas double in the summer and monsoon. Impetigo, foliculitis, furunculosis and infected Miliria are common alongwith ecthyma and cellulitis. Most oozing dermatoses show evidence of secondary infection with streptococci and staphylococci.

Leprosy in India accounds for 70% of world leprosy[5] skin tuberculosis is still seen in India[6] with scrofuloderma, lupus vulgaris and TBVC being the commonest clinical variants. Many cases of lupus vulgaris, and TBVC are localised at sites of truamma such as buttocks, hands, feet, elbows and face, which has been attributed to a lack of adequate protection of footwear and clothing and chances of traumatic inoculation from dust contaminated with AFB due to indiscriminate spitting by open cases of pulmorney tuberculosis.

Borderline Tuberculoid (BT)

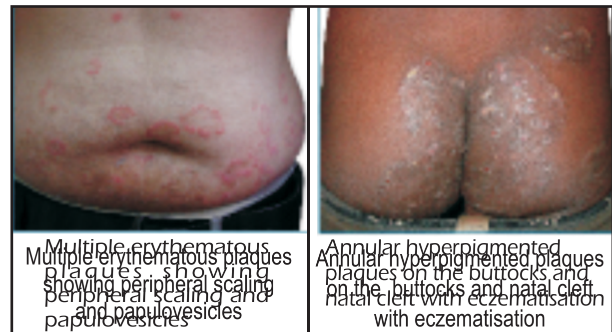


Superficial Fungal Infections

SFI of the skin, nails and hair accounts for 8-10% of all skin OPD. The incidence increases during the summer & monsoon. Tinea cruris and corporis are the commonest variant seen. Aetiologically, Trichophyton rubrum tops the list, followed by T. Mentagraphytos and Epidermophyton floccosum, Microsporum canis.

Tinea capitis is more common in rural population and the low socio economic group.

Candidiasis :


Multiple erythematous plaques showing peripheral scaling and papulovesicles | Annular hyperpigmented plaques on the buttocks and natal cleft with eczematisation

Intertrigo, Paronychia are common in rural population in which candida albicans is the most common aetiologic agent.

Sexually Transmitted diseases are yet another group of disease influenced by socioeconomic factor. Migration of youth to industrial cities in search of employment has led to many of them living alone in overcrowded slums away from their families. This coupled with illetracy, ignorance and lack of entertainment, leads to sex as only recreation easily available. This results in a higher incidence of STD's in those belonging to the low socio economic class.

Syphilis still remains the commonest disease, followed by gonorrhoea and NSU, Chancroi, LGV and donovanosis.

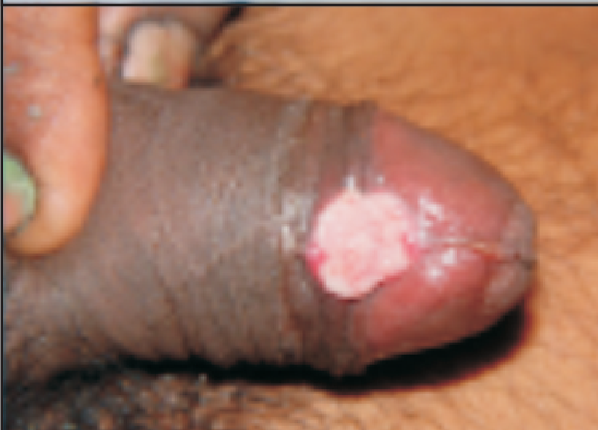
Parthenium Dermatitis:

Parthenium hysterophorus is a weed that way introduced in india with imported wheat grains. Sunlight plays a role in this dermatitis which is mostly seen in young men.

Miscellaneous :

Polymorphic light eruptions in indian tends to form chronic plaques.[7] Drug induced

Primary Syphilis



Single, painless, well defined ulcer with clean looking granulation tissue on floor.
Indurated
Hard chancre - heals with scar even without treatment

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photosensitivity in indian often occur in the form of lichenoid papules.[8]

Study of Manglore :

Analysis of 36 73 cases showed (2225 males and 1448 females) attended skin OPD showed (11.16%) patterns having skin diseases. 260 (63.41%) of them were males, 150 (36.59%) females of there 178 (43.40%) had infectious dermatoses and 243 (57.07%) had non infectious dermatoses. Fungal infections were seen in 22.5% of Pts. and eczema an upper hand in noninfectious group (32.19%). Psoriasis and other papulosquamous seen in (2.43%) pt., Pigmentory diseases in 2.92%, Acne and autoimmune disease (12.68%) and congenital and hereditory diseases in (4.3%) patients.

CONCLUSION

The magical year of 2000 AD has come to an end. Health for all by 2000 AD' remain as a distant mirage and the slogan has been rephrased as 'Health for all in 21st Century'.

To improve the prevailing situation, the problem of rural health is to be addressed both at the macro (national and state) and micro level (district and regional), in a holistic way, with genuine efforts to bring the poorest of the population to the centre of the fiscal policies. A paradigm shift from the current 'biomedical modes' to a 'Socio Cultural modes' is required to meet the needs of the rural population. A comprehensive revised national health policy addressing the existing inequalities and work towards promoting a long term perspective plan exclusively for rural health is the current need.[1]

Improvement in the standard of living, education of the general public, improvement in environmental sanitation and good nutritious food may help us to bring down the skin diseases.[3]

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