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PHYSICIAN IN WAR

Dermatology in War

I still laugh at the memory of nurse Katarina's bewilderment and disgusted expression on her face when she called me to examine Boško in our field medical office. Boško looked like one of those images in a dermatology atlas: his back and posterior aspect of his extremities were covered with erythematous scaly plaques and silvery squames. Silvery scales could be seen in his hair, and the hair border was deep red. Typical psoriatic skin changes – I could make diagnosis from the office door.

At that time, my knowledge of dermatology was modest, just student memories of typical skin and venereal diseases and allergy reactions which need urgent treatment, such as Quincke's edema, as I learned at the Emergency Service of the Split University Hospital before the war. Luckily, dermatological diseases with complex clinical picture and differential diagnosis were not common among young and healthy soldiers. Their dermatological ailments were rather simple and straightforward. They would come for dermatomycoses caused by poor feet hygiene and poorly ventilated boots that they sometimes kept on their feet for days. I never sent such cases to the dermatologist, but made a diagnosis myself on the basis of erythema, skin scaling, and interdigital itching, and prescribed antimycotics *ex iuvantibus*. Those with serious complications, such as bleeding ragades and pain, I would hospitalize in our field hospital and provide local treatment: hypermanganese baths and occlusion bandages with antimycotic and anti-inflammatory preparations.

The soldiers also came with plantar verrucae, usually when the verrucal ingrowth caused pain during walking. Excochleation and topical keratolytic treatment always solved the problem. Inflamed corns and calluses were also a frequent sight. Some of us, especially at the beginning of the war, did not have proper soldier boots. We wore sneakers, sports shoes, or hiking boots. When we finally got the uniforms, our sensitive civilian feet had to undergo a process of adapting to the hard and strong shoes, which were sometimes either too big or too small. Few days of rest, adequate anti-inflammatory therapy, and change of boots would solve the problems.

Nail ingrowth, especially on the toes, was a more serious problem. Because of strong inflammation and infection with abundant purulent secretion in some cases, sometimes I had to use local anesthesia to remove all nail segments from the inflamed tissue. The soldiers complained that the application of the anesthetic around the inflamed region was often worse than wounding on the battlefield. Oral antibiotic therapy was regularly used in combination with local therapy in such serious cases.

As disturbances of sebaceous skin glands are common among young people, seborrheic facial skin and acne were not rare among my soldiers. Inappropriate hygienic conditions of the battlefield and caloric, often dry, food did not help those with such skin problems. But they did not complain or seek help for this – it was not important; esthetics and beauty were not really relevant at the battlefield. However, for those I saw suffering inwardly from that problem, I would have our pharmacy prepare lotions and shampoos.

Some more adipose soldiers suffered from erithrasma of the inguinal region. Skin folds, tightened with heavy uniform, sweating, and friction, caused the development of mixed bacterial and mycotic infection of the sensitive skin. They came when the pain became unbearable, and said that they felt ashamed – because of the region where the infection appeared and because I would think that they did not keep themselves clean.

During my three years of medical work on the battlefields, despite horrible conditions, I never encountered cases of scabies or pediculosis.

Allergic reactions in the form of acute urticaria were rare, and developed most commonly as a reaction to preservatives contained in tinned food. I had a few cases of allergic exanthemous reaction to medicaments, usually antibiotics (penicillin or sulfonamide) or analgesics. The reactions were not serious and vanished after a few days of diet and parenteral administration of antihistaminics and corticosteroids. Such soldiers had to stay for a few days in the field hospital because of sedative effects of the antihistaminics.

Rarely, soldiers would call while on home-leave and ask to prolong their stay because of urinary problems. When they came back with the medical documentation, I would see that they were treated for non-specific urethritis. I had no cases of sexually

transmitted diseases – I suppose that those who had such problems asked their local physicians for help during their leave. They were probably too embarrassed to speak to me about such things. Anyway, they would have needed specialized treatment and bacteriological analysis, and hospitalization.

Boško, a soldier from the beginning of this story, has had discrete lesions in his hair for a long time, but ascribed them to his long-lasting seborrhea and dandruff. He did not know of other members of his family to have had such problems. The papulo-squamous scaly eruptions had appeared first on his elbows and knees and then on the back before more than a month, but he had not complained. Only when the eruptions spread all over his body, he had no choice but to visit me. I sent him to the Dermatology Department of the Split University Hospital. I also explained my nurse Katarina about the disease and asked her to restrain herself from showing open disgust over any patient.

These days, when I read reports on psoriasis written by my colleagues from over Croatia, I see that there is increased incidence of psoriasis among resident civilians, refugees, and Croatian soldiers. Also, most patients who had psoriasis before the war experienced frequent exacerbations of the disease or even relapses after more than 20 years without symptoms. Many atypical clinical presentations of the disease were recorded, such as the appearance of the plaques in the inguinal region, periannally, on the scrotum, under or between the breasts, or on the palms of the hands and soles of the feet. Eruptive forms of the disease were also more common, especially after wounding, surgical interventions, or some serious disease (tonsillitis, pneumonia, or viral respiratory infections). Psoriasis also became more common in children, sometimes as early as the age of two, as well as among older persons. Older patients had extensive lesions, which often progressed into erythrodermia. Many patients with a classical clinical presentation of the disease developed psoriatic arthritis. Such serious clinical presentation of psoriasis could be ascribed to war stress – loss of loved ones, homes, war threat – factors that may have exacerbated this at least partly psychosomatic disease. To a very small number of psoriatic patients, life on the battlefield and persistent engagement in active defense of their country presented some kind of psychological compensation and source of inner relief, which stabilized or even improved the disease.

My colleague from Sisak wrote that "psoriasis in war was an infallible indicator of high levels of inner tension, but also the measure of the inner balance, from establishing strong self-control to complete loss of any."

After the war, I specialized in dermatology. Boško is still my patient. He regularly comes to phototherapy and photo-chemotherapy, and has some trouble with psoriatic arthritis. He deals with his chronic illness well, saying he fared well in the war. He often jokes that he not only kept every part of his body, unlike many others during the war, but even got some extras.

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