My reply to the SKIN DISEASES CROSSING BORDERS Article on Clubdermaweb

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Dear Adriana Mello

I read your paper and the references you have used and backed up your claim with great attention however many of the statements are not factual and I find myself obliged to reply to them one by one. Your paper is written in a way as to serve a source of misleading information and as an invitation for those of us who are ignorant about certain facts. I will use assertions and factual references to prove that it is not the case at all and we all know in medicine that we commit to truth and integrity, with that said, all things are possible. Without that, nothing else matters.

As a medically qualified doctor in dermatology in Libya, I can say that most of what has been stated is not right and it is a brutal indictment (or accusations) against migrants, international travellers, international child adoption, and refugees and it can't be considered as you have stated as skin diseases crossing borders. You could say common skin diseases from other continent as we all know, certain places according to their geography could incur such a thing specifically, however stating that as well won't be enough for such a description.

For instance scabies and lice come from intimate contact and poor personal hygiene and are more prevalent in one of the greatest world countries such as the UK and till now it is on the rise as many articles had pointed out1 and I do have relatives who are infected by it. Scabies have no country of origin or boundary either – it is all prevailing. On the contrary it's a disease that can break out in the winter time specifically when there is a crowd and using infected articles like bed linen and towels and it has been reported in hotels in one of the most developed countries such USA, Australia and the UK and the EU. Thus it has no origin really.

Moreover leishmaniasis is common in tropical disease of mountain areas however it is not infectious per se as you have put it, and It merely needs the sand fly bite (vector-borne disease) in order to develop the ulcer.

Furthermore, we cannot deny the fact of HIV origin and its spread in the 80s and the world war plague. HIV spread mainly in the developed world and we all know how it started emerged and basically due to sexual attitudes, HIV is more prevailing.

Additionally cupping has nothing to do with any ulceration as you have declared? And I am not sure where that information comes from.

Also you have stated the tungiasis (a burrowing flea inflammatory skin infection) as an infected issue and this can be found in tropical parts of Africa, the Caribbean, Central and South America.

Also how can acne be an immigrant infection? It is a state of most teenagers and has no basis for that claim and was not either stated in your provided references.

Also lyme is a tick bite infection, and cellulitis and pyoderma are basically bacterial infection? Thus I am not sure what the message is here nor your accusation.

You have said and affirmed all that are potentially skin infections. I am not sure on what basis is that made on.

Also you stated sunburn, contact and irritant dermatitis? Fixed drug eruption? Cutaneous larve migrans? Herpes simplex? Herpes zoster? Pox virus? Spider bite? As a transferable potentially skin infection. We all know that is not the case and all of what you stated are merely a speculation with no evidence base at all in medicine.

In the paper that you have used, it has stated that 'sun exposure is uncommonly associated with life-threatening conditions, but its long-term consequences on the skin can be as harmful, something any traveller should be warned about'. Also you have mixed up the statement of contact dermatitis and you have put it in a way as its in itself an infectious thing, however the paper cites it as a marine creature exposure would cause a contact dermatitis after sea anemone exposure (3).

Lastly you stated that MRSA is another infection crossing the border as well? Well we know all that MRSA is purely a noscomial infection and had a direct relation to the hospital environment, infection control measures, such as hand hygiene, and infection cross spreading? So I am not sure of its applicability in this. Plus the paper you cited was about ozone therapy for staph aureus and MRSA.

A search however was carried out in the Pubmed for the last ten years yielded only three articles about different topics and not specifically about dermatologic infections in migrants.

You added those dermatologists who are confronted with rare skin infection should check anamnesis and follow-up on travel routes (itinerary) and country of origin in order to reach a proper diagnosis? It only reflects a gap in staff knowledge and I fully agree as this would open the horizon to the challenge of different endemic disease origin where it is poorly known in Europe and not to claim the concept of the skin crossing border is a migrant issue.

In keeping with this, there are many more important matters and diseases spread to be concern about internationally than skin diseases travelling.

You had used GeoSentinel data as a reference and reading this paper stated the fact of returning traveller and excluded migrants for your knowledge if you have read the paper carefully and used the word that Data cannot be used to infer quantitative risk for illness. Moreover it had spoken about different illness and not only dermatological disease specifically as you had put in clearly. Moreover the GeoSentinel data source was mainly from travellers acquired their illness in Asia (32.6%), followed by sub-Saharan Africa (26.7%) and Latin America and the Caribbean (19.2%). North Africa and the Middle East; Europe; North America; and Oceania, Australia, and New Zealand (2).

Also the GeoSentinel data used the dermatolgical diseases which accounted for only 19.5% and didn't use the word infection which would imply a different meaning and prospect. It has also used the description of insect bite and rabies and soft-tissue infections, and rash or itch which you didn't state for reasons i don't know. You could have put travel-related diagnoses rather than the title you have used for your paper. You ignored the fact of Legionella was acquired in Europe and it has been stated in the GeoSentinel data as well, however you didn't point out about it and just put the whole blame on one party (2).

Also you didn't state that Tungiasis and myiasis are less frequently diagnosed in travelers. However, this issue of the Journal of Travel Medicine includes a case series of 90 travelers diagnosed with furuncular myiasis in Israel. And in the series of myiasis, there were more cases related to Dermatobia hominis than Cordylobia anthropophaga just because patients were returning more from South America than from Africa 3.

Yours sincerely

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References:

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3. Monsel G, Caumes E. What's New in Travel-Associated Dermatology? J Travel Med. 2015 Jul-Aug; 22(4):221-4. doi: 10.1111/jtm.12224.