5th Dr. W. D. H. Perera Memorial Oration 2017

To deliver holistic dermatological care – striking the right balance and treading the best path

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The chief guest Prof. Christopher Bunker, President Dowling Club UK, Guest of honour Mrs Laura Davies, the President of Sri Lanka College of Dermatologists Dr. Janaka Akarawita, Past Presidents, Dr Vinitha Perera and members of the family of Late Dr. WDH Perera, members of the council, my teachers, members of the Sri Lanka College of Dermatologists, visiting members of the Dowling Club of UK, distinguished guests, ladies and gentlemen.

It is a honour and a privilege for me to deliver the Dr. WDH Perera Memorial Oration this year and I thank the President and the Council for according me this great honour.

Late Dr. WDH Perera had his education at Ananda College Colombo, where he excelled both in sports and studies.

Subsequently he entered and graduated from University of Peradeniya.

While at Peradeniya he met his future wife Dr. Vinitha Perera.

Having obtained his MRCP UK he returned to Sri Lanka and was appointed as Consultant Dermatologist to General Hospital Ratnapura.

Late Dr. WDH Perera was instrumental in developing dermatology to a well-recognized and respected specialty in Sri Lanka. He also played a key role in establishing the South Asian Regional Association of Dermatology.

For this work he was awarded a life time achievement award posthumously, by the Prime Minister of Nepal.

His long standing friendship with late Dr. Gunther Shwenzer, paved the way for the long standing cooperation that exists between German Dermatological Society and Sri Lanka College of Dermatologists.

He was a person with many talents. His bird photography is a testimony to this.

My association with Dr. WDH Perera, commenced when I joined the dermatology fraternity as a postgraduate trainee in 1994. Along with my mentor Dr. DN Atukorala, Dr. WDH Perera has had a profound influence on my career, but more so has been a father figure, adviser and friend in time of need.

Following completion of my overseas training in dermatology at St. George's Hospital London, UK, under the tutelage of Prof. Peter Mortimer and Dr. Alan Marsden, when I returned to Sri Lanka in 1996, we had 11 consultants serving a population of 18 million.

I consider myself, blessed to have commenced my 20 years journey as a consultant in the cradle of Sri Lankan civilization in the ancient city of Anuradhapura located in the dry zone in the North Central province. It was

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the first kingdom established dating back to 500 B.C. and yet boasts of magnificent ruins and venerated by Buddhists all over due its to historical Bo Tree – Sri Maha Bodhi, a sapling of the original, which assisted Lord Buddha in attaining enlightenment in India.

Anuradhapura General Hospital, the largest in the province drained mainly an agriculture based population of 750,000, who were involved with paddy and chena cultivation. When I took over, only a clinic service was available and the large size of the province coupled with poor transport caused much hardship to complicated patients requiring close observation and follow up.

Hence, I made it my personal crusade to convince the authorities of the need of a ward and finally succeeded in opening a brand new ward, which has since rendered yeoman service. In spite of other shortcomings such as lack of pathological services for our principal diagnostic tool, the skin biopsy, we treated a large number of patients both in hospital as well as through satellite clinics held weekly in remote villages.

Other than common dermatological problems such as dermatitis, a large number of tropical skin infections from mundane to complicated deep fungal and tuberculous infections presented to my clinic.

Another challenging factor at that time was the proximity to the North of the country, where a bloody civil war was raging. Travel home to Colombo to visit family on public transport always carried the risk of getting caught in a bomb blast, a frequent occurrence at that time. Incidentally a large number of soldiers formed a significant number of my patients.

However, in spite of these challenges my work brought me great joy and satisfaction mainly due to a dedicated and enthusiastic team of staff and trusting patients.

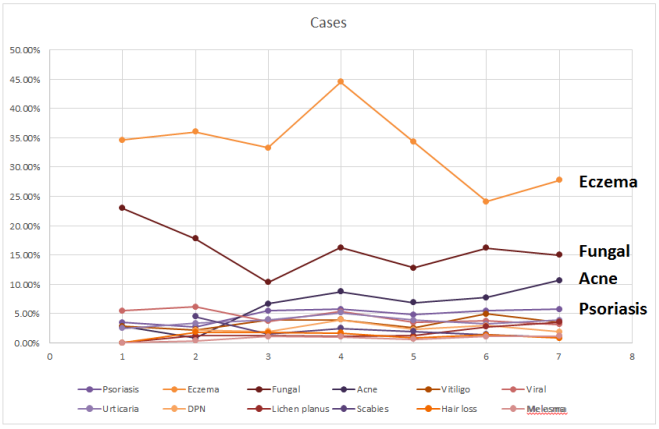
Indeed, it is admirable that our visitors today, the Dowling Club of UK, visited Sri Lanka for a joint meeting 20 years ago regardless of these turbulent times and risks.

My next transfer to General Hospital Kegalle with a drainage population similar to Anuradhapura i.e. 780,000 is located in the Sabaragamuwa Province, which boasted of a more salubrious climate due to its location in the wet zone. Here again there was no dermatology ward and I set about the usual business of making a nuisance of myself to the authorities until they provided a new ward.

My spectrum of dermatological diseases were similar with many tropical infections, which we showcased during a regional clinical meeting. Here, I take a moment to present the skin clinic attendance patterns around this period. A study conducted by Dr. Prasad Kumarasinghe in 1994 at GH Matara in the South of Sri Lanka, showed that dermatitis was the commonest condition followed by fungal infections, with a smaller proportion of other infections and psoriasis. Acne was a mere 2.8%, similar to vitiligo, which did not appear to be a priority to patients at that time. A few years later in 1998, a community study in an urban area conducted by Dr. Antoinette Perera and Late Dr. D. N. Atukorala – my mentor gave some interesting insights in to the patterns of prevalence of dermatological diseases. Out of overall 32% having some skin condition, majority (23%) had fungal infections – mainly pityriasis versicolor followed by dandruff and dermatitis. Interestingly acne was found in a significant 4.5%.

When we compare with more recent data – an audit conducted at my clinic in CNTH Ragama in 2006 and at the NHSL within the recent years we can make these interesting observations. Both in 2006 and 2016 dermatitis remains the number one cause of a dermatological consultation. However, there is a gradual but, significant decline in the proportion to other conditions. Being a tropical country the second highest cause for skin clinic attendance remains fungal infections, but a drastic reduction from 23% in 1994 to 14% in 2016 is observed.

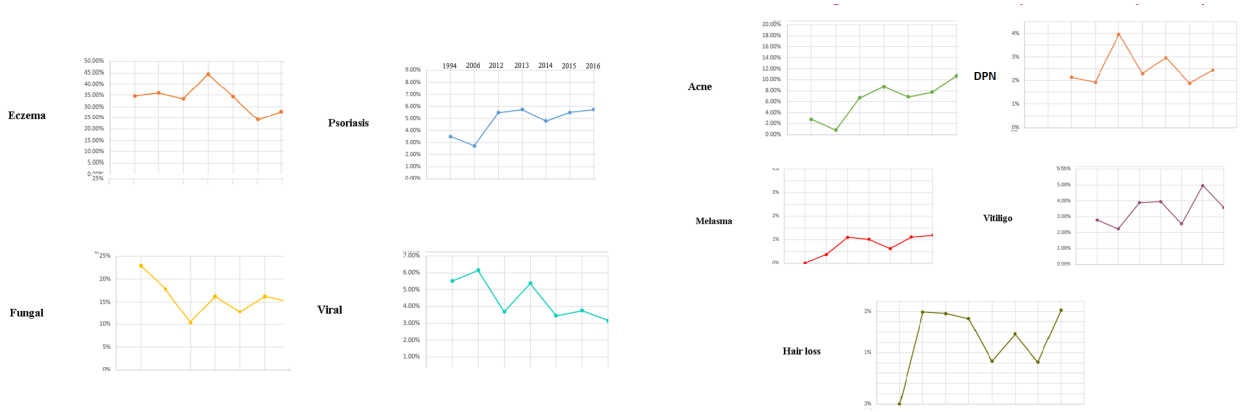
Trends in dermatological clinic attendance patterns over past 20 years



1 – **1994** Matara Clinic Study
2 – **2006** CNTH Clinic Audit
3 – **2012** NHSL Clinic Audit
4 – **2013** "
5 – **2014** "
6 – **2015** "
7 – **2016** "

This slide shows these patterns more clearly. A slightly higher % of psoriasis is also seen. However, this breakdown of graphs shows a very interesting point in that the population of patients with acne has significantly increased.

Trends in dermatological clinic attendance patterns over past 20 years



Now, I wish to focus on other changes that have occurred in Sri Lanka, which could have had an impact on dermatology, over the past 20 years.

Although, we are currently classified as a lower middle income country, our gross domestic product and gross national income per capita are showing an upward trend towards an upper middle income country. Our population is growing, but slowing down and the mean population density has increased to 325 per square kilometer with Colombo district having a staggering 3,487 / sq km. Over half the population is concentrated in the Western, Central and Southern provinces jointly covering less than 1 / 4 of the total land area.

Our literacy rate is one of the highest in the region at 95.7%. 81% of households have access to safe drinking water, 98.3% of households have their own toilet facilities according to census and statistics of 2012.

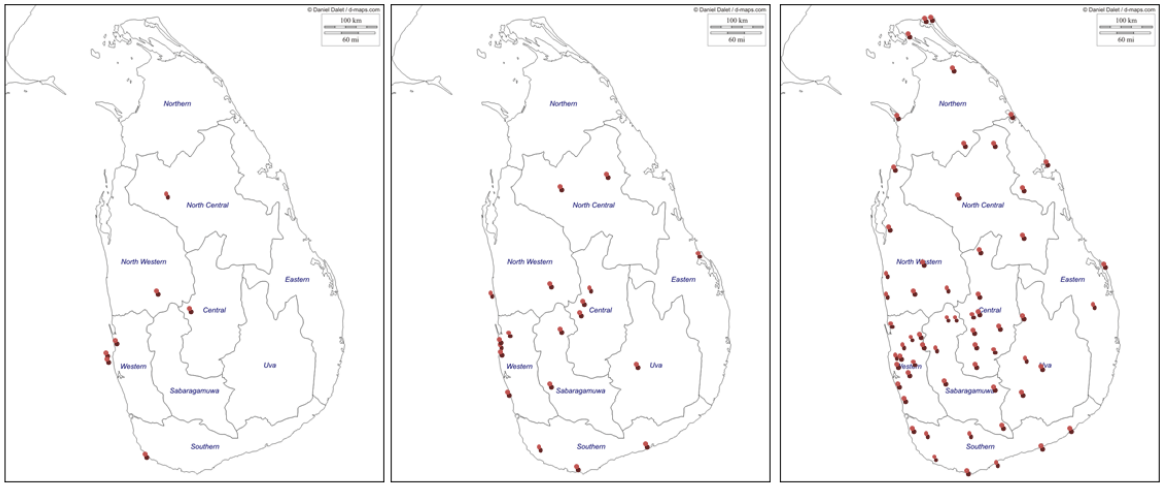
The age composition of the population over the past years showed a reduction of those < 15 years and increase of those > 60 years. Accordingly the population of Sri Lanka is gradually shifting to an aging population.

We have some of the best health indicators of the region. The first table shows our average life expectancy to be 76.35%, much higher than our neighboring India, but lower than UK. This graph and table shows the enviable reduction in infant and maternal mortality. The WHO has declared our country to be free of polio, malaria and more recently filariasis.

We have enjoyed a state sponsored free healthcare service for many years in spite of only 3.5% of GDP accounting for health expenditure with the majority seeking treatment at government health institutions. However, according to the National Health Accounts of Sri Lanka 2013 a significant 44% of healthcare financing is been borne by people seeking treatment in the private sector.

If we look at how, dermatology has changed as a specialty over the past 20 years, the number of consultant dermatologists from 11 in 1996 had increased to 17, 10 years later that is 2006. However, there has been an explosion of numbers by 2016 with the current tally standing at 76 – having achieved the target cadre projected in 2007. Moreover, every corner of Sri Lanka is covered by a consultant.

Changes within dermatology as a specialty – Past 20 years



1996 — 11

2000 — New MD Dermatology curriculum introduced

2006 — 17

2009 — Ethnic war ended

2016 — 76 — Target Cadre Achieved

The two most important events that have brought about this change is the recruitment of large numbers of post graduates into the new MD curriculum introduced in year 2000 by pioneering dermatologists like Late Dr. D. N. Atukorala and Late Dr. W. D. H. Perera. The second event was the end of the civil conflict in 2009 and opening up all parts of the country.

My career shifted to the Western Province in 2002 to BH Panadura, a coastal town where I came across a large number of patients with leprosy. Subsequently, I was transferred to Colombo North Teaching Hospital Ragama in 2005. Being a teaching hospital, a wide range of challenging and interesting dermatological problems were tackled here. Subsequently, in 2013, I came to the National Hospital of Sri Lanka the premier tertiary care hospital of the country, where again a wide array of complicated and difficult to manage patients are seen on a daily basis. Most of my data is based on the latter 2 hospitals.

Meanwhile in the International Arena of dermatology, many new exciting developments in both diagnostics and therapeutics was taking place. Along with the advent and refinement of lasers the term "cosmetic" or "aesthetic dermatology" became the buzz word. In keeping with these trends, this topic was introduced to our MD dermatology curriculum in 2003 and I was assigned as the resource person.

Let me transgress here to give you a better understanding of the term dermatology, this is defined as the study and treatment of conditions of skin, hair and nails in both adults and children. As opposed to the bulk of this specialty, which is "medical dermatology" dealing with accurate DX and appropriate RX, there is "procedural" or "surgical dermatology", which involves performance of minor surgical procedures. In the aforementioned new branch of aesthetic dermatology, the emphasis on improving or enhancing the appearance of the skin.

Although, there is a tendency to compartmentalize these 3 branches, I believe they often overlap. The aesthetic component plays a greater role when dealing with facial issues, even though it may be asymptomatic or non-life threatening.

Sometimes, the dermatological issue causing disfigurement is congenital, as in this baby, with a vascular anomaly, the man with a plexiform neurofibroma or the one with pachydermoperiostosis. More often embarrassing scarring is acquired – is the result of diseases, both benign and serious such as deep fungal infections, leprosy etc, which once successfully treated could yet result in scarring and deformities. Irrespective of whether the condition is trivial or serious the aesthetic effects can have severe negative psychological impact. Many studies have shown that skin diseases leads to severe psychological distress and depression, which interferes with the quality of life, more so when affecting visible areas like the face due to perceived social stigma.

I am of the opinion that treatment of a dermatological disease does not end with the treatment of the acute phase. I sincerely feel we must try to bring the skin back to a near normal state. Hence, I say, dermatological treatment is inexorably tied up with aesthetic outcome. With the dermatologist's in depth knowledge of skin physiology and pathology, he or she is uniquely qualified to deliver skin care to both diseased and non-diseased skin. We must familiarize ourselves with current best practices and provide these to our patients making maximum usage of facilities at our disposal.

So, I propose that the previously mentioned 3 branches are a continuum from one to another and should be complimentary to one another to deliver total dermatological care.

Being a South Asian country the average Sri Lankan has brown skin and is of Fitzpatrick skin type 4 and 5, which have a low tendency to burn with ultraviolet ray exposure. Incidentally, it is this same brown pigment melanin, which accounts for the low incidence of skin cancers in comparison to fair skinned people.

However, there are several challenges we face due to our dark skin. The first is the high propensity to develop seborrhoeic warts ranging from pin point to larger ones. In fact, my first exposure to aesthetic dermatology was treating these using trichloroacetic acid more than 20 years ago. This is a study conducted by our unit, where we studied the characteristics of this condition among 200 individuals attending the OPD. Warts were found in children as young as 12 years. Majority were females and a strong family history was elicited. 97% of lesions were asymptomatic and 40% were worried about them. In comparison to the 1994 study where the number presenting with this was negligible our current data at NHSL shows a steady increase.

Nowadays instead of acid cauterization, we perform electrocauterization under topical anaesthetic cover, which gives more predictable, precise and excellent results, and our recent data of the number of EC sessions at NHSL show a progressive increase reflecting the aesthetic concerns of today's society.

The next challenge due to dark skin is the tendency to hyperpigmentation both reactive and spontaneous. Many dermatological diseases such as lichen planus, acne and blistering disorders lead to post inflammatory hyperpigmentation.

The commonest spontaneous hyperpigmentation is melasma, which is symmetrical and favours sun exposed areas such as cheeks and is known to be more prevalent in darkly pigmented races and can have far reaching social and psychological impact. Although, exact pathogenesis is not fully understood, genetic factors, sun exposure, contraceptive pill, pregnancy and phototoxic drugs may play a role. There are currently no guidelines for the management of this therapeutically challenging disorder. As our graph shows there is a progressive increase in the numbers presenting to our clinics.

My postgraduate trainee studied 28 consecutive patients with facial hyperpigmentation at NHSL during a 4 month period in 2015. We used a state of the art skin physiology apparatus known as the Mexameter to quantify the pigmentation in different underlying causes as well as to assess therapeutic response. Majority of those presenting were females (85%) with majority having melasma. Both pre and post treatment readings were higher in PIH, but, not statistically significant. We treated these patients with a high strength 70% Glycolic acid peel, which had not been carried out or reported here previously. We found satisfactory reduction in Mexameter reading supported by clinical observation as seen in these patients with both conditions.

Another common form of spontaneous facial pigmentation we encounter is periorbital melanosis of different degrees. As there is a dearth of published data, we studied the clinical nature and histopathology in 82 patients at skin clinic CNTH in 2010. A statistically significant association was observed with deep set eyes and the degree of melanosis. There was positive correlation with atopy. Skin biopsy showed melanin incontinence, which has implications when planning treatment.

When I commenced my career 20 years ago we had very little to offer our patients with both hyperpigmented and atrophic scars secondary to acne. As our graph shows the proportion of patients with acne presenting to us have increased significantly. Hence, we were delighted to have Prof. Nanna Schürer from the University of Osnabruck, Germany, from the German Dermatological Society visiting us in 2006 to introduce a novel procedure i.e. chemical peeling.

Facial chemical peeling is defined as the application of an exfoliant chemical to the skin resulting in controlled destruction of layers of epidermis or dermis with resultant regeneration of new tissue. Although many experts in the West have expressed reservation about risk of hyperpigmentation of this procedure in dark skin, we have found it to be an excellent tool, if performed according to guidelines.

I commenced the first chemical peeling clinic in Sri Lanka at Colombo North Teaching Hospital in 2006 and continued this work even after my transfer to National Hospital of Sri Lanka. During a 5 year period we performed a total of 931 peeling sessions using 3 chemicals. The cheapest and most readily available was TCA and comprised 870 sessions. Glycolic acid 30% to 50% was used in 51 sessions with the remaining done with 30% salicylic acid. The main indications were acne scars and facial melanosis. We were able to achieve satisfactory results with the main complication being post peeling hyperpigmentation, which too responded to topical therapy. Since, this period I am happy to note many of my postgraduates introduced it all around the country.

Although, the issue of superficial acne scars was sorted with chemical peeling, I was frustrated by our inability to offer much to those with deeper scars. Acne is a common disease of the pilosebaceus unit affecting upto 80% adolescents resulting in scarring to some degree in 95%. One in seven have disfiguring scars and along with acne, this is a risk factor for suicide.

Therefore, when I came across a novel low cost method known as subcision “subdermal incisional undermining” first introduced by David Orentreich et al. I decided to try it on our patients at CNTH. We published the treatment outcome of 15 patients treated with subcision for rolling acne scars. Our results showed at least 40% improvement in all 15 patients, with all of them expressing satisfaction. The percentage improvement depended

on the depth and severity of scars. Side effects were bruising and swelling in 1st week and one developed PIH, which resolved at 3 months.

Subsequently, I adopted the dual combination of chemical peeling and subcision as complimentary methods. An audit presented at our annual sessions 2013, showed that the majority were females in the 15-35 age group. Out of 111 patients who underwent chemical peeling, 6 developed hyperpigmentation and out of 62 patients who underwent subcision, 1 developed secondary infection. At that time, I recommended the combination as ideal for resource poor settings. A recent audit at NHSL showed a steady increase of the number undergoing subcision and 97 patients underwent chemical peeling with an average of 3 sessions.

The next landmark event in aesthetic dermatology in Sri Lanka was the purchase of a dermatological laser to the NHSL in 2015. Although, Dr. Leon Goldman first used this as far back as 1963, the big revolution occurred in the 1980's and during the past 2 decades there was an explosion of research. With recent rapid advances in technology with refinements, it is now widely accepted and considered safe and used for a wide array of skin disorders.

Unfortunately, due to prohibitive cost, Sri Lanka is several decades behind in the usage of this technique. This delay has paved the way for many dubious establishments offering the service to the public.

As a policy, laser therapy at NHSL is offered only to those having predominantly pathological indications rather than as a beauty tool. In my unit at NHSL, we have performed 230 sessions on 84 patients with indications ranging from capillary malformations to rosacea to keloids and leishmaniasis using PDL and NdYAG for severe facial hirsutism.

More recently, laser has seen a rapid increase in the private health sector. On searching we identified 3 laser centers affiliated to hospitals, 3 independent laser clinics and 3 dermatologists having private lasers. However, when we look around, we find much larger numbers of advertisements and billboards offering laser treatment by non dermatologists.

When we analyzed the pooled data of laser therapy in the private sector of 2 colleagues and myself in 2016, the following interesting observations were noted. A total of 246 patients had undergone laser procedures with 4 types of machines. Majority (84) underwent hair removal with NdYAG or Diode laser with an age range of 16 to 61 years majority being 20 to 40. As expected majority were females with only 3 males and 2 transgenders. A similar number had undergone CO2 laser for mainly acne scar resurfacing with an age range of 21 to 57 years, 2/3rds being females. A lesser number underwent Qswitched laser Rx for pigmentary conditions like freckles, melasma and naevi, with an age range of 19 to 56 years with the majority being females.

Thus, with this growing evidence on demand for more aesthetically related dermatological conditions, we decided to look for evidence as to who was meeting these needs. We scanned 2 reputed weekend newspapers for aesthetically connected advertisements within the past 10 years. This chart shows the average number found on a Sunday with relation to cosmetology courses, cosmetic clinics and spas and we found an upward trend over the years, with beauty parlours mushrooming in all corners of the island.

We also looked at the data from the National Vocational Training Institute (NVTI) on the number of yearly recruits since 2006 for courses on beauty therapy, hair dressing and more recently cosmetology. The number in all categories have increased. My purpose in presenting this data and trends is not to point fingers, but, to highlight the demand for aesthetics from our society. In an era when a person is judged by their outward appearance, I acknowledge the service rendered by beauticians who help people to achieve their best. We should not view them as rivals, but, instead use their services as a complimentary extension to ours. Unfortunately, although reputed and well trained beauticians extend a responsible service within their capabilities some beauty quacks seem to step beyond their domain induced by lucrative financial gain.

Trends in demand for aesthetic dermatology in Sri Lanka

Numbers receiving National Vocational Qualification (NVQ) certificate for beauty therapy in Sri Lanka

Year	Beautician	Hair Dresser	Cosmetology	Grand Total
2017	620	328	15	963
2016	2985	1094		4079
2015	2903	992		3895
2014	1160	704		1864
2013	2125	1156		3281
2012	1882	957		2839
2011	1395	695		2090
2010	1023	701		1724
2009	990	890		1880
2008	928	740		1668
2007	238	261		499
2006	27	7		34

Source – National Vocational Training Institute

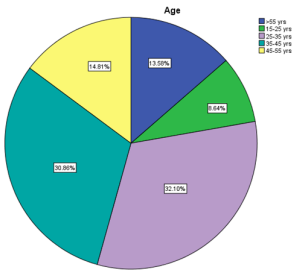
Data regarding the number of cosmetic products registered over a 4 year period at the Cosmetics Drugs and Devices Authority shows an increasing trend in all categories. Mercifully, the number of fairness creams is lower in 2015 compared to 2012, confirming our suspicion that the large number of fairness creams available on the market today are unregistered products, due to lack of a regulatory authority for cosmetics since 2015 in Sri Lanka.

Data from a recent survey we conducted among the National Hospital staff and students. The average profile of the cosmetic user is as follows. The highest usage of cosmetics was between 25 to 45 years with 85% being females. Majority of those using cosmetics were employed with an income bracket between 30,000 to 60,000. Majority used up to 3 products with the commonest being moisturizers, cleansers, fairness creams and hair dyes.

Survey on cosmetic usage among hospital personnel at NHSL – February 2016

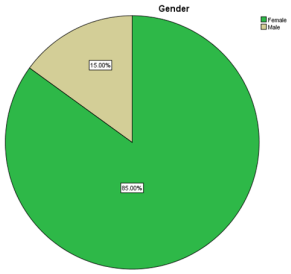
Total No. – 103
No. found to use cosmetics – 81

1. Cosmetic usage by **Age**



Highest usage 25 to 45 yrs

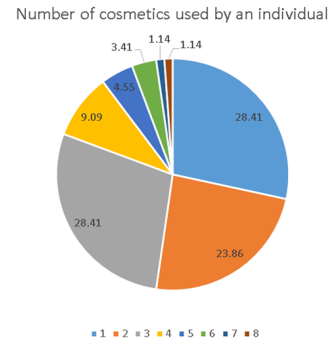
2. Cosmetic usage by **Gender**



Majority (85%) - **Females**

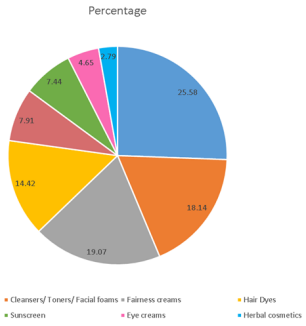
Survey on cosmetic usage among hospital personnel at NHSL – February 2016

5. According to no. of products used by an individual



Majority used up to 3 products

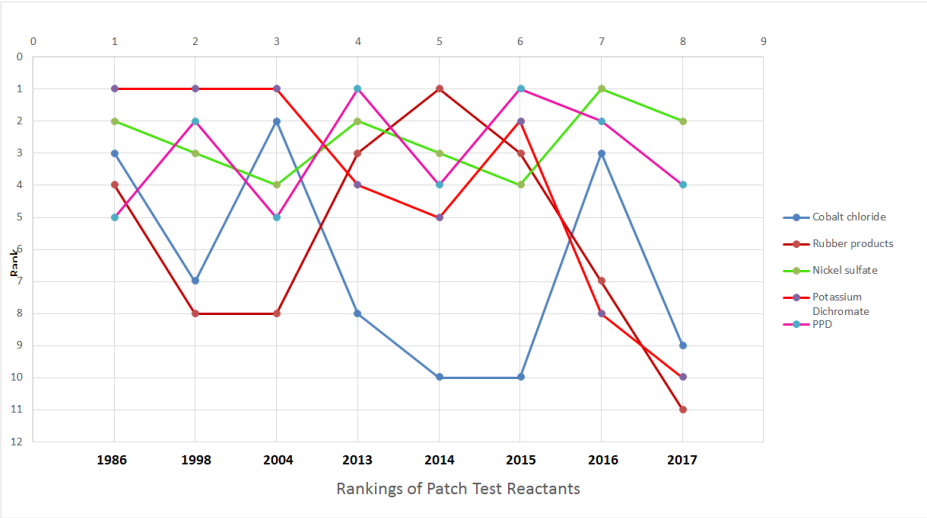
6. Cosmetic usage according to **type of cosmetic**



Commonest cosmetics – moisturizer . Cleanser, fairness creams, hair dyes

This trend for increasing cosmetic usage is reflected in our patch testing data as well. Patch testing is a procedure where a standardized allergen is applied to the patient's skin in order to identify culprit allergens responsible for contact dermatitis. A retrospective analysis of 244 patients who underwent patch testing during a 3 year period in our unit at NHSL, showed hair dye allergen, paraphenelene diamine topping the list of allergens.

Trends in patch testing allergens positivity, since 1986 to date



When we compared our data with previous available data, some surprising trends are observed. The previously commonest culprit allergen dichromate found in cement has drastically reduced. Hair dye allergen positivity has increased, reflecting an increasing usage of hair dye. Nickel found in costume jewelry has also increased, possibly reflecting the trend for this replacing traditional gold jewelry.

Other than contact dermatitis, we have observed many other adverse effects due to cosmetic usage. One area of particular concern is the craving or obsession with becoming fair. Currently, the concept of beauty seems to be equated to fairness, mainly perpetrated by TV, newspapers and social media. Our market is flooded with whitening creams, some produced by reputed multinationals, some by beauticians and some being home prepared passed around in unmarked containers. Unsuspecting, unfortunate young people who use these products present to us with contact allergies, severe acne and pigmentary changes both hypo and hyperpigmentation, raising the suspicion that strong steroids and bleaching agents have been incorporated into these.

At this point, I would like to share with you a review article, which appeared in the *Journal of European Association of Dermatology and Venereology* in June 2016, where toxic chemicals such as strong hydroquinone (HQ), monobenzene ether of HQ, which kills melanocytes permanently and mercury were found on analysis of whitening agents in Europe. The authors conclude that freely accessible illegal cosmetics caused side effects and demand public education and product transparency.

In a press release by the Center for Environmental Justice and the Friends of the Earth Sri Lanka in 2013 highlighted the high levels of mercury in whitening creams in Sri Lanka. However, thus far, Sri Lankan authorities have not taken any meaningful steps to either comprehensively analyze cosmetic products for toxic ingredients or brought in any control measures to curb this menace, in spite of a request by the Sri Lanka Medical Association. Our College has initiated a study group on cosmetic dermatology to campaign on this further.

Interestingly, as article published in the *International Journal of Dermatology* in February 2017, on historical aspects of cosmetic usage shows that this obsession with fairness is neither recent nor limited to dark skinned races. Queen Elizabeth the 1st in the 1500's, developed frontal alopecia secondary to usage of lead containing whitening cosmetics.

Recently, wide media coverage was given to a number of instances of botched and unsafe beauty procedures carried out by untrained individuals, such as some of my patients, developing viral warts following eyebrow threading and another patient who underwent an unsightly eyebrow enhancing tattoo.

Although, I have presented you with aesthetic challenges of the dark skin, one of the growing trends in the West appears not to be reflected here in Sri Lanka. That is the demand for anti-aging solutions of the skin in spite of availability of Botulinum Toxin and Fillers. I believed this is mainly because of our slower photo aging process compared to light skin due to our pigment laden skin preventing penetration of ultra violet rays of the sun into our dermis and therefore mitigating the ravages caused by the tropical sun.

As the dark skin developes less wrinkling compared to fair skin with advancing age. Another possible explanation for low demand for anti-aging procedures could be prohibitive cost and non-permanent nature requiring repeated sessions. Furthermore, at present our social fabric is dominated by religious and cultural taboos and inhibitions regarding elderly who traditionally are not encouraged to strive to look younger. Unfortunately slower ageing is not applicable to hair and these cultural taboos conflict in the minds of many of our elderly who crave to retain black colored hair.

In many developed countries there is a huge upward trend in demand for cosmetic procedures. Factors contributing are economic growth there by improved affordability, booming middle class with high disposable incomes, revolution in mass media and thereby increasing awareness about cosmetic procedures as well as the increase in medical tourism. In the modern era it has become a fancy, a fashion and patients are becoming more demanding, having unrealistic expectations and wanting their money's worth. Due to lucrative income and sometimes due to over enthusiasm on the part of the doctor and succumbing to demanding patients, there is a growing list of dissatisfied patients with obliging lawyers targeting doctors with malpractice litigation.

Although, this type of senseless and extreme scenario is not common in Sri Lanka at present, with further financial empowerment, there is a very real possibility of aesthetic dermatology spiraling out of control in Sri Lanka. It is our responsibility to strive to prevent this happening here. Hence, it is essential that the dermatologist understands the needs of the patient and choose the right patient for the right procedure maintaining a doctor patient relationship built on the foundation of trust. Counseling patients prior to procedure and obtaining informed consent is mandatory. The standard of care practiced by the dermatologists should be on current best evidence available.

So ladies and gentlemen in conclusion, Sri Lanka is rapidly advancing in terms of economic, social and health indicators. People are stepping beyond traditional dermatology and are more concerned with self enhancement. Simultaneously, cosmetic usage has increased. Due to our dark skin type we face special challenges such as propensity to hyperpigmentation and wart formation.

Faced with this overwhelming evidence for demand for aesthetic dermatology, we as dermatologist are at crossroads, and could walk along one of two extreme paths. The first is to reject cosmetic dermatology as a frivolous undertaking and thereby create a vacuum. The second is to embrace it fully and allow aesthetic dermatology to displace all other work for lucrative financial gain.

Dermatologists are best suited to deliver optimal skin care to both diseased and non-diseased skin. The country has the necessary cadre of dermatologists serving in all regions. The dermatologist must develop the correct attitude towards aesthetic dermatology as a continuum of medical and procedural dermatology.

Due to unmet demand causing a void, and lack of proper legislature, individuals of dubious capability are offering suboptimal and even dangerous services to unsuspecting patients. We must keep up to date with best practices and acquire necessary skills never losing sight of the fact that medical dermatology forms the bulk of our work and the most rewarding

Aesthetic dermatological services can be further enhanced by using the services of beauticians. Since, there is a lack of legislature and accountability at present, we must campaign for these in order to safeguard our patients. We must prevent the trusting doctor patient relationship turning into a business transaction.

Hence, I propose that we should avoid extremes and tread the middle path, accept new changes while retaining old values and strive to mete out balanced and holistic dermatological care.

Acknowledgements

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I also thank Dr. Janaka Akarawita, Dr. Nayani Madarasinghe and all others who provided me with data. Mr. Zalmi Kassier and Yumal Chathuranga for computer assistance and my patients who have placed their trust on me during my career.

On a personal note, I thank all my teachers, colleagues and friends who have supported me in many ways especially Prof. Janaka De Silva and Dr. Indira Kahawita for valuable advice, and finally my husband Romesh for being the wind beneath my wings.