Integrative management of disease in India could extend to wound care but needs more financial support

SR Narahari

I work at a truly multidisciplinary centre — The Institute of Applied Dermatology (IAD) — in Kerala, India where we have developed an integrated approach for the treatment of lymphoedema. In India, lymphoedema is most commonly cased by lymphatic filariasis, a tropical disease that particularly affects the poor and is transmitted by mosquitoes. The integrated approach that we use combines both biomedical systems of medicine with ayurveda (India's major traditional system of healthcare), homoeopathy, physiotherapy and yoga. But despite our success in providing locally-available, low-cost, patient-led and evidence-based care, our centre will struggle to progress and develop and extend our treatment protocols to chronic wound care, due to under-funding.

As a dermatologist, trained in 'Western' biomedical practice, I am involved in clinical research in my role as patient-oriented researcher (PORer), as well as hands-on care. As the team leader I help colleagues to arrive at the best possible judgments during our 'integrative management' of dermatoses. Our team, which is mentored by T J Ryan, Emeritus Professor of Dermatology at Oxford University, comprises health service providers including biomedical dermatologists, an ayurveda physician, a yoga therapist, a homeopath, counsellors, a clinical nurse, social scientists, botanists and a statistician. Patients attending our integrative dermatology clinic are examined and diagnosed on the basis of standard guidelines combining a provisional diagnosis (based on biomedicine), nidaana panchaka (ayurveda) and totality of symptoms (homeopathy). These assessments are reviewed by the team through cross-medical dialogues. My biomedical diagnosis and outcome measures are adhered to during follow-up and whenever indicated, I use biomedical investigational tools to provide objective evidence.

Dr SR Narahari is Dermatologist and Patient-oriented Researcher at The Institute of Applied Dermatology Kasaragod, Kerala, India

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With more than a decade of experience we have realised that ancient ayurveda, embedded in Sanskrit, describes most of the symptoms and signs that we observe in patients today — although the diagnostic nomenclature and indications for drugs are less clearly transferable. A multi-medical team can effectively observe these clinical signs and symptoms and summarise them into a universally communicable tabular form (Narahari, 2007) that helps to select appropriate treatment available in Indian systems of medicine. Our team also has frequent communication via e-mail with international experts who help us with each treatment protocol that we develop. In addition the team is also fortunate to receive guidance from the international advisory board attached to the Institute of Applied Dermatology.

Chronic wounds are not uncommon in our patients. They are particularly associated with lymphoedema and venous insufficiency. While treating these wounds we begin by eliminating infection by initiating appropriate antibiotics on the basis of culture and sensitivity testing from the wounds. We keep gauze soaked in Jatyadi Taila, a herbo-mineral oil, on the wound bed for a few days until it debrides the wound and fresh granulation tissues appear over the moist areas of the wound bed. Later low-adherent, absorbent dressings (melolin) are applied over the wound until the discharge completely dries out. Hydrocolloid dressings are also used in certain patients. Along with general measures such as compression bandages and foot end elevation, ayurvedic medications Kaishora guggulu mixed with khadiradi kashaya are administered orally. There are 84 types of topical medications, 33 oral medications and 60 procedures narrated in ayurveda that remain to be explored (Dwivedi, 2007).

Our centre's approach has had dramatic success in the management of lymphoedema in India (Narahari et al, 2007). In a medically pluralistic society our patients generally give written consent before they receive integrative treatment. In this vast country patients come to IAD from eight provinces and some people travel more than a day by train for an appointment. Our team produces information sheets in different

languages to cater for the needs of our patients. IAD is also piloting patient-oriented research to develop integrative treatment protocols for chronic wounds, lichen planus, vitiligo, psoriasis, chronic idiopathic urticaria and verruca vulgaris.

We are a young organisation in rapid development and we work in an inadequate, primitive setting with very poor infrastructure. We are housed in a rented building and we outsource facilities at commercial rates to a local hospital to meet the ancillary needs of our inpatients. Ultrasound is expensive and when needed we refer our patients to a private sonology consultant. For investigations we depend on local blood testing centres that network with larger urban laboratories. Open access internet site BioMed Central, free medical journals and 'author pays' journals act as our library. Influenced by the lack of funds we continue to believe in networking and making the best of our existing facilities.

Goldstein and Brown (1997) said that successful POR teams display a passionate curiosity about disease; deep involvement with patients; have infinite patience; and the ability to withstand poverty in terms of grants. Our team also exists in this 'poverty'. Except for a grant from India's Department of Science and Technology, to pilot the methods to conduct systematic reviews for Indian Systems of Medicine, cross-subsidisation from profits generated from clinical revenues of IAD is our only major support. Financial constraints force the team to see patients for 75% of the time leaving less than 25% for POR-related responsibilities and documentation, reading, discussions and writing papers. All of our studies are currently unsponsored.

POR, if rare in the USA, is virtually unheard of in India. Until the time Indian grant-making agencies, industry and managers of philanthropic funds realise that 'a gene sequence is not a drug' (Goldstein and Brown, 1997) our efforts to provide low-cost, evidence-based and locally available integrative skin care to poor and needy Indians will probably not develop beyond its present form and our attempts to extend these methods of treatment to wound care will flounder.

Such efforts at institutionalising patient-oriented integrative dermatology, being an intimate collaboration between biomedical dermatologists and ayurveda physicians, provide relief that neither could give alone to meet the great need to relieve the burden of skin disease and lymphoedema that ruins the lives of so many in India. WUK

Further information about the Applied Dermatology Institute can be found at www.indiandermatology.org

Dwivedi K (2007) Ayurveda and wound healing. In: Shukla VK, Raj Mani, Luc Teot, Pradhan S eds. *Management of Wound Healing*. Jaypee Brothers Medical Publishers, New Delhi: 181–93

Goldstein JL, Brown MS (1997) The clinical investigator: bewitched, bothered, and bewildered—but still beloved. *J Clin Invest* **99**: 2803–12

Narahari SR (2007) Lymphodema management in India. *J Lymphodema* **2**: 10–2

Narahari SR, Ryan TJ, Mahadevan PE et al (2007) Integrated management of filarial lymphodema for rural communities. *Lymphology* **40**: 3–13