Editorial

War and Rebuilding: What Can We Expect in the Aftermath of the War in Iraq?

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The major fighting in Iraq is over, and the work of rebuilding has begun. What can we expect in the months ahead? America is deeply invested in the rebuilding of Iraq, and our presence there is likely to continue for some time. Over the ensuing months, servicemen will return home with maladies acquired overseas. The potential for continued unrest in the region makes it likely that western countries will continue to receive a stream of asylum seekers, as well as the medical conditions these individuals bring with them. Dermatologists at home will see and treat these exotic diseases, the burden of which may endure for some time. A study of Southeast Asian immigrants in Australia demonstrated that intestinal parasite infections were still common 12 years after immigration.[1]

Dermatologists will play a significant role in treating these patients, as dermatologic diseases are prevalent among those seeking asylum in western countries. A study of 1487 refugee children in the Canton of Zurich found that almost 10% had skin diseases.[2] Among Vietnamese refugees arriving in Hong Kong, chronic bacterial skin infections and lice were common problems,[3,4] and Southeast Asian refugees living in Tennessee have presented to their physicians with chronic bacterial infections, including leprosy and parasitic diseases.[5]

A series of articles that covers the health problems encountered during war and rebuilding is timely, and of value to *Cutis*® readers. Important topics to be covered include dermatologic diseases endemic to Iraq and Afghanistan, diseases common in refugee and immigrant populations, and the continuing threat of bioterrorism. These articles will focus on problems that we may encounter at home and abroad.

A review of the health problems of soldiers during the last Gulf War gives us a sense of some of the problems we should be prepared to treat. Fortunately, the rate of infection with exotic diseases during that conflict was quite low considering the magnitude of our presence in the region. Approximately 800,000 coalition troops were deployed to the Persian Gulf during Operations Desert Shield and Desert Storm. The liberal use of insecticides and repellents played a major role in reducing the incidence of disease. The deployment of most ground troops in the open desert during the cooler winter period also was important in reducing the number of reported infections, because these conditions were unfavorable for the transmission of arthropod-borne diseases. In contrast to World War II, there were no reports of sand fly fever among coalition forces during the first Gulf War, and there were only 31 cases of leishmaniasis among the 697,000 US troops. Although the region contained suspected vectors of cutaneous leishmaniasis, sand fly fever, West Nile fever, Rift Valley fever, and Crimean-Congo hemorrhagic fever, the prevalence of infection was low during the months of the war and was confined mostly to leishmaniasis.[6] In addition to cutaneous leishmaniasis, there were 12 cases of visceral leishmaniasis due to *Leishmania tropica* during the first Gulf War.[7]

Vector control efforts during a prolonged peacekeeping and rebuilding effort may be more complicated than during the war. We are likely to remain in Iraq during the change of seasons, and vector-borne disease may be a more significant problem. We also should remain alert for signs of bioterrorism.

In addition to treating returning servicemen, western physicians will play a major role in providing

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healthcare to those displaced by the conflict and to a nation plagued by more than a decade of war and degraded infrastructure. Before the first Gulf War, many of Iraq's healthcare professionals were foreign nationals. War and a crumbling economy led to a mass exodus of healthcare professionals. Doctors' salaries were reported to fall to about $30 a month, barely enough for subsistence.[8] As the economy decayed and money was continually diverted to the Iraqi military, there was little available to spend on public health measures. American forces and international aid agencies are now faced with the task of rebuilding a nation destroyed by years of war and isolation. We will confront malnutrition, malaria, tuberculosis, leishmaniasis, and infestation.

Over the next few months, *Cutis* plans to publish a series of articles focusing on the role of the dermatologist during war, rebuilding, refugee crises, and humanitarian missions. (For the first article, see page 39 of this issue.) We also will feature editorials on the role of military medicine in our national response to bioterrorism and the continuing role of military residency training programs. We hope this series of special articles will be helpful to our readers, as we pull together a nation to help with the work ahead.

REFERENCES

1. de Silva S, Saykao P, Kelly H, et al. Chronic *Strongyloides stercoralis* infection in Laotian immigrants and refugees 7-20 years after resettlement in Australia. *Epidemiol Infect*. 2002;128:439-444.
2. Neuhaus TJ, Smaadahl F, Losa M, et al. New faces, forgotten diseases: border medical examination of asylum seekers' children 1990-1991. *Schweiz Med Wochenschr*. 1992;122:1838-1842.
3. Samuda GM, Chan SP, Yeung CY. Vietnamese child health in a Hong Kong closed camp. *Aust Paediatr J*. 1988;24:115-117.
4. Pickwell S. Protocol: health screening for Indochinese refugees. *Nurse Pract*. 1983;8(4):20-21, 25, 35.
5. Dao AH, Gregory DW, McKee LC. Specific health problems of Southeast Asian refugees in middle Tennessee. *South Med J*. 1984;77:995-997, 1000.
6. Cope SE, Schultz GW, Richards AL, et al. Assessment of arthropod vectors of infectious diseases in areas of U.S. troop deployment in the Persian Gulf. *Am J Trop Med Hyg*. 1996;54(1):49-53.
7. Hyams KC, Hanson K, Wignall FS, et al. The impact of infectious diseases on the health of U.S. troops deployed to the Persian Gulf during operations Desert Shield and Desert Storm. *Clin Infect Dis*. 1995;20:1497-1504.
8. Akunjee M, Ali A. *Med Confl Surviv*. 2002;18:249-257.