

Preface Bioterrorism



Boni E. Elewski, MD
Guest Editor

Biological warfare has gained recent attention in the public and medical literature. This issue of the *Dermatologic Clinics* reviews the topic of bioterrorism as it pertains to dermatology. Cutaneous presentations are common with many biological warfare agents and may appear soon after a biological terrorist attack. It is conceivable to assume that in this situation dermatologists would become front-line responders. Prompt and accurate diagnosis would result in early medical intervention, which could reduce mortality. Therefore, knowledge of the clinical features of likely biological warfare agents is important for all dermatologists to become familiar with. For example, during the anthrax attacks in the fall of 2001, dermatologists made the initial diagnosis of cutaneous anthrax in the New York City cases, which brought to the public attention the unique expertise of dermatologists as the authorities in cutaneous disorders. Many dermatologists were soon called upon to educate the public and the medical communities on cutaneous manifestations of anthrax and other worrisome bioweapons.

The first article in this issue extensively reviews the history of biological warfare and will include detailed discussions on the anthrax attacks of 2001. Although anthrax is caused by a bacterium, the cutaneous and systemic pathology are the result of a toxin. This is discussed in the article by Drs. Wenner

and Kenner, which emphasizes the cutaneous manifestations and diagnosis of anthrax. The next article, written by Dr. Henghold, reviews other biologic toxins that have potential as bioweapons, such as ricin.

Following the terrorist attacks on the World Trade Center and the anthrax attacks on New York City and Washington, DC, there was much concern about the use of smallpox as a bioweapon. Consequently, a mass vaccination of the military and some civilians occurred. The article by Dr. Hanifen thoroughly reviews this virulent disease. Additionally, variola vaccine reactions have become another concern; this is addressed in the article by Dr. Fallon-Friedlander.

The final three articles review other biological warfare agents, including the article by Drs. Baddley and Salvaggio on Ebola, hemorrhagic fever, and related diseases. Although plague occurs sporadically in nature it can be used as a biologic agent; this topic is reviewed by Drs. Cobbs and Chansolme. Finally, miscellaneous bioweapons, including tularemia, are discussed by Dr. Cronquist.

This issue of the *Dermatologic Clinics* is designed to familiarize the reader with common cutaneous presentations and provide an overview of the pathogenesis of select biological warfare agents. Knowledge of their clinical changes and pathogenesis will likely hasten diagnosis and would hopefully mitigate the result of a biological attack. Although it is an

important area for dermatologists to master, the study of biological cutaneous manifestations of biological warfare agents has been somewhat neglected in residency training and received little attention until after the terrorist attacks in New York City. I hope you enjoy reading this interesting and informative edition of the *Dermatologic Clinics*.

Boni E. Elewski, MD
Professor of Dermatology
The University of Alabama at Birmingham
700 Eighteenth Street, South, EFN 414
Birmingham, AL 35233-0009, USA
E-mail address: beelewski@aol.com