Dermatologist’s role in leprosy elimination/post-elimination

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Introduction

We believe that NGOs, engaged in leprosy control in metropolitan cities where there are many dermatologists in medical colleges, or in private practice, have a special responsibility in implementing leprosy work in an integrated manner. It may be worthwhile narrating the experience of over 3 decades of the Bombay Leprosy Project (BLP) as the Project has been constantly striving to practise all aspects of management of leprosy in an integrated manner, so that any NGO or an institution interested in following this model may be benefited.

With the advent of short course MDT in 1982, it was realized that such involvement was even more crucial. The BLP project started a massive programme with the following objectives:

1. To improve the quality of diagnosis and field classification.
2. To promote the practice of MDT as per national guidelines.
3. To enhance the quality of care for management leprosy complications.
4. To implement long term surveillance for monitoring treatment efficacy.
5. To explore the possibility of collaborative research.
6. To offer all facilities and promote partnership (with BLP) towards the common goal of leprosy eradication.

These objectives will remain relevant as long as all problems related to the disease are taken care of.

Due to the severe isolation in which the city leprosy programme was practised and the stigma prevailing among the medical profession and even the teachers in medical colleges, priority was given to start leprosy clinics in the Dermatology Departments of the Medical Colleges, though it was by no means easy. A visit of Dr W. H. Jopling to Bombay was taken advantage of to arrange lectures in teaching institutions not only to talk about leprosy but with
the object of clearing misconceptions about transmission. This allayed the apprehensions of the hospital authorities and they offered clinic space in the out patients department of dermatology. The offer by BLP to start more clinics was extended to both government and private medical colleges and hospitals run by Municipal Corporation. Later, a separate room could also be obtained in the Department of Preventive and Social Medicine in one of the Municipal medical colleges.

Right from its inception in 1976, BLP has been experimenting with several strategies and methods, to sensitize and involve dermatologists of the local medical colleges as well as those who were in private practice. Slit skin smears (SSS) facility was made available to all the medical colleges and practicing dermatologists especially when it was the essential component of the WHO treatment regimens but were not uniformly available.

Prevention of disabilities (POD) was the most neglected component of the leprosy control programmes. Assistance was provided in the areas of splints, specialized footwear, ulcer dressing kits etc. Even essential drugs were supplied to various clinics. It is heartening to note that these services are being requested with increasing frequency.

Changes in the medical curriculum will depend upon the degree of awareness and knowledge about the disease among medical students, doctors and dermatologists. This was achieved by arranging talks by national and international celebrities in the field of leprosy, providing training, conducting regular CMEs, publication of wall journal, assisting the residents and faculty to select leprosy related subjects for thesis, in the presentation of material at the conferences and further helping them for its publication in the scientific journals.

To further strengthen its base, BLP has been involved in various research activities including drug trials and evaluation of various new regimens. We are now into an arrangement with Department of Preventive and Social Medicine of K. J. Somaiya Medical College and Research Centre to post all medical interns by rotation for a period of 1 or 2 weeks in the BLP monitored projects.

Role in post-elimination era

We believe that with the decline in expertise available so far from the ‘vertical’ specialty of leprology, the future of disease management in the post-elimination phase is likely to be more challenging. Hence, following are the areas where dermatologists and medical colleges/institutions and even NGOs have a major role to play:

Clinical

1. Clinical problems and complications that are difficult to be managed by primary care health facilities should be referred to the nearest dermatological clinic/medical college, which need to be identified area wise depending on the expertise available.
2. Leprosy NGOs with expertise should network with practicing dermatologists and medical colleges to provide technical assistance for slit skin smear facility, management of complications and prevention and care of deformities.
Operational

1. After the integration, the programme is now transferred from leprosy workers (vertical) to general health care workers. The need for establishing ‘Referral Centres’ either at the district level or at sub-district level has been should be re-emphasized.
2. Dermatology departments in medical colleges should serve as Specialized Guidance Centres by establishing linkages with other allied departments for providing specialized services to leprosy patients such as reconstructive surgery and medical and physical rehabilitation, physiotherapy etc.
3. Public health dermatology should be encouraged to attract young dermatologists interested in public health programmes like leprosy especially in rural areas.
4. MDT blister calendar packs may be made available to the interested practicing dermatologists and they should be requested to maintain simple records, networking with NGOs/local health facility for follow-up of patients.

Training

1. It would be useful to utilize the services of the dermatologists in the medical colleges to train medical officers, nurses, physiotherapists, and paramedical workers about basic diagnosis and treatment of leprosy.
2. The skills and knowledge on leprosy should be imparted to undergraduates / interns/postgraduates and they should be exposed to community health.
3. Periodic dermatological training programmes will be essential to ensure that leprosy is not taken as a forgotten disease and to sustain the knowledge and skills about the disease.
4. Update on leprosy about changing National Leprosy Eradication Programme (NLEP)/-WHO policies through CME programmes for dermatologists.

Conclusion

These techniques, studied extensively over the past 30 years, have been instrumental in meeting the objectives of BLP (stated above), viz. integration of leprosy management with the general health sector of which the medical colleges and dermatologists and practicing physicians forms a crucial component. These techniques and strategies have been largely responsible for bringing in awareness, initiating the dermatologists in the teaching institution as well as in the practicing sector and enabling them to take on the challenge in the post elimination era. We believe that this model of integration is replicable in any other comparable metropolitan city in India.

The public at large, donors and even the intellectuals are made to believe that since leprosy has been declared ‘eliminated’ by the Government of India, specialists and specialized services will no more be necessary in the field of leprosy. Problems of diagnosis, routine treatment and management of complications like reactions and nerve damage, POD, rehabilitation etc. have to be tackled mainly by the trained medical officers and specialists. A smooth transfer of technology in managing leprosy to the non-leprosy sectors and enhancement of their competence should therefore be the responsibility of the ‘vertical’ system in which leprosy NGOs have a vital role to play.
Every now and then, doubts are being raised by some groups especially clinicians whether India declared elimination of leprosy as a public health problem rather hastily. A careful post-elimination surveillance system, by experts in government and private health sectors is essential to assess the achievement of elimination in India.

Bibliography