This issue of *Leprosy Review* has widely contrasting papers, reflecting our aim to publish good research related to leprosy in a wide range of fields.

Pandey *et al.* report a valuable study comparing profiles and outcomes of patients treated before MDT was implemented and during implementation in the government leprosy programme in Chhattisgarh, central India. They found that there were still large numbers of new cases with an NCDR of 11.9/10,000 population in 2002. There had been a striking improvement in the defaulter rate, from 57% pre MDT to 12% during MDT. The relapse rates were low at 0.9 and 1.4% for PB and MB cases, respectively. Interestingly the reaction rate had increased significantly to 10.8% for PB cases and 19.4% for MB cases. These figures emphasize the strength of leprosy programmes, and it is vital that these success continue in the integrated setting. They also highlight the importance of reactions. It is important that reactions be detected and treated promptly in all settings.

Paul Sunderson and Ruth Leekassa have produced an interesting report on the ILA Africa Leprosy Congress held in February 2005. Papers at the conference showed that the number of new cases is not declining and that there is still a high rate of grade 2 disability, indicating that delays in starting treatment remains a major obstacle.

Diagnosing leprosy is not always easy and in another paper from Africa, Faye *et al.* did a prevalence study on hypochromic patches in rural children. They found that hypochromic patches are found in 4% of these children. Fortunately, they are mainly caused by fungal infections. However, this highlights the importance of training health workers to differentiate hypochromic patches caused by leprosy from those caused by fungal infections.

Pankaj Sharma *et al.* report on a huge double blind immunoprophylactic study testing the effectiveness of *Mycobacterium w* vaccination in household contacts in preventing leprosy. A total of 24,060 household contacts were vaccinated with placebo or control, with surveys at 3, 6 and 9 years after initial vaccination. A protective effect of 68.6% was found at year 3, but this had declined to 39.3% by year 9. So vaccination has a definite protective effect, but it may not last long enough.

We also publish the report of a workshop held in Addis Ababa in October 2004. The reviews are timely updates on the current status of diagnostic tests for leprosy. New antigens have been identified from the *Mycobacterium leprae* genome analysis some of which are showing notable specificity in being recognized only by leprosy patients. However, these studies will have to be expanded to larger numbers of patients. Careful thought will also have to be given to deciding how best to use these diagnostic tests and what the implications would be if these were used as screening tests.

We also have an abundance of case reports this issue. One from Brazil contributes more light on the interesting interaction between HIV and leprosy. In contrast to tuberculosis, being HIV positive is probably not associated with an increased risk of leprosy. However, starting HAART with the consequent improvement in immune status does seem to permit the clinical development of leprosy and type 1 reactions. This series of five cases reinforces this finding, and now leprosy should be seen as an immune reconstitution phenomenon in people put on HAART (highly active anti-retroviral treatment).

It is a pleasure to publish an edited version of the LEPRA prize winning essay in 2004. The winner was Joy Rafferty, with an essay on stigma; the runner up Michelle Williams with an essay on compliance in leprosy.

**Diana N. J. Lockwood (Editor)**