Editor’s Choice June 2012: Scales for measuring everything

This issue has the theme of measuring and using scales. We have papers on assessing empowerment scales, reaction severity scales and using the salsa scale in Brazil. Bakker and van Brakel (pp. 129–153) have done a systematic review of scales used to assess empowerment. They found that although 17 questionnaires had been developed and an Empowerment tool developed none of this work has been done in a resource poor setting. So the tool needs to be assessed rigorously and in new settings to determine the cultural appropriateness of the scale. It is encouraging that such scales are being developed for leprosy work and will be important in producing data on stigma. Tools for measuring stigma are important and will be needed to measure the impact of stigma reduction interventions. Walker et al. (pp. 154–163) have developed and validated a scale for measuring leprosy reactions which was validated in Brazil, Nepal and Bangladesh. This scale has now been assessed further by physicians and show correlation with clinically important changes. This gives us an important tool for measuring reactions. The SALSA scale for measuring activity limitation was developed and validated several years ago. Nardi et al. (pp. 172–183) used it and the WHO disability grade assessment to assess life post treatment in a cohort of patients in Brazil. They found that the SALSA scale identified more limitations of activity than the WHO disability grading score. This scale can therefore be widely used in programmes to measure life after cure.

Neuropathic pain post leprosy treatment is an increasingly recognised problem. The Brazilian study on activity limitation found that pain was an important post treatment factor limiting participation 54.7% of these treated patients having pain that limited their lives. Chen et al. (pp. 195–201) have studied neuropathic pain inpatients living in Chinese leprosy villages. In this group 48% had moderate to severe pain and for 94% their sleep was disrupted. They also use self medication with analgesics and steroids. These two studies highlight the importance of pain as a post treatment problem. Other work has identified leprosy reactions as a risk factor for developing pain. This gives us further reason for ensuring that leprosy reactions are detected and treated promptly. Trials on effective treatments for neuropathic pain are also needed. Steroids are probably not effective in patients who have been treated long ago. And the role of a hierarchy of analgesics needs to be identified.

Shen et al. (pp. 164–171) report on the long term outcome of 83 patients with a high BI who were treated with 6 months of Uniform Multidrug therapy (U-MDT). The BI fell from a mean of 2.83 to 0.33 by 42 months after U-MDT. However one patient (BL) relapsed 13 months after treatment. These workers also found 29% of this cohort had leprosy reactions mainly occurring after drug therapy.

Leprosy is now at very low levels in Mexico; Larrea et al. (pp. 184–194) have analysed the national reported data from 1989–2009. There are still over 200 new patients detected annually and the new case detection rate is slowly falling. There is also considerable heterogeneity in the case distribution with more cases on the west coast. New patients are getting older, but two of the new younger patients had household contact with leprosy, which highlights the importance of screening household contacts. Diagnosing leprosy in Mexico will now become more difficult and perhaps it would be a good setting to test initiatives for detecting patients in low endemic settings.

We have three interesting editorials, one of which is looking at the synergies that might be found between leprosy and other Neglected Tropical Disease (NTD), and Smith et al. (pp. 121–123) look at Uganda and Nigeria to illustrate their case. We are also publishing the editorial on training needs in full.
to correct our omission in March 2012. The third editorial is by Griffiths (pp. 124–126) and he makes a very powerful argument for taking a rights based approach to ensure that patients with disability have equal access to poverty reduction programmes. He promotes the use of a new tool, the Umbrella model to identify household vulnerability. He also notes that although there has been much lip service paid to inclusion in Myanmar only 4% of organisations could identify activities designed to promote inclusion. It would be interesting to see what the picture is elsewhere.

So this issue we have covered scales for measuring everything from reactions to stigma.

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