Editorial

Leprosy is among the world’s oldest and most dreaded diseases. Through the lack of any effective remedy in its long history, with the hideous deformities it produced and in the absence of any scientific information about its transmission, it acquired a stigma and aroused morbid fears which led to an extra degree of discrimination. Leprosy has tormented humans throughout history, leaving lasting impressions on religion, literature, and art. In the medieval period, leper colonies and asylums sprung up where victims of this untreatable disease would go to die slowly. Later on missionaries, establishment of leprosaria (more to protect the unaffected), Christian organizations and some private charitable though rudimentary hospitals played a momentous role in the care of leprosy patients.

For these unfortunate sufferers, the situation became hopeful with the introduction of sulphones in the 1940s and still more encouraging after the introduction of MDT in 1981 and it actually brightened when the World Health Assembly in 1991 adopted a resolution for its Global elimination by the year 2000. During this time, the control and care of leprosy patients has been gradually taken over from the missionaries, sympathetic health workers, and the NGOs by governmental medical officers and specialists in leprosy. So the era of housing and rehabilitating patients in leprosy colonies gradually transformed to that of reconstructive surgery, teaching of professional skills and social rehabilitation. From a disease considered due to a divine curse and managed as a purely social disease, leprosy became a chronic but curable disease amenable to corrective surgery and even gainful rehabilitation. From more then four million in 1980 to an estimated less than 200,000 leprosy patients by the end of 2006 is a stupendous achievement which has happened due to the introduction of MDT and continued involvement of WHO, ILEP, SMHF, TNF, NOVARTIS, DANIDA-DANLEP, SIDA, ALM, LEPRA, DFB, World Bank and National governments. Leprosy is no longer an incurable disease, leaving affected individuals and their families to suffer its devastating consequences without hope. Today, the diagnosis and treatment is considered simple and is available at most of the health centres- free of cost.

After the integration of the leprosy related services in to the general health care, patients, though in smaller numbers, will continue to present with leprosy. This may lead to some problems for instance-in an earlier issue of Leprosy Review, existence of huge disparities between the quality of services available in Uganda for the management of complications has been mentioned. Following continued urbanization and industrialization and consequently movement of populations over large areas, the disease is likely to be encountered sporadically by the health care providers all over and will not merely be confined to endemic pockets in a given country. In such situations the most imperative concern is the availability of the expertise for special situations like reactions, neuritis, deformities, trophic ulcers, relapses and drug resistance. In one of the editorials in Leprosy Review (2005) it was clearly stated that of the many challenges facing leprosy elimination, the struggle to maintain the pool of the skilled and the knowledgeable health workers/ experts was the most important. It was suggested that “on the job” training may be the best strategy to enlarge the pool. The choice of trainer naturally would fall on a specialist who has read, known and seen the disease and has been a part of the management team with plastic and reconstructive surgeons during his/her
career. This specialist, obviously, is the dermatologist who during his post-graduate course has been taught even the differential diagnosis of leprosy as part of the curriculum, and this is what is being followed (though to variable degrees) throughout Africa, Asia, and Latin America. In principal sufficient time in all the regional and national conferences of the dermatologists is always devoted to leprosy. The dermatologists in government service or private practice form a large pool and provide coverage to a very large population. Moreover, the first contact of the patient with skin lesions (including that of leprosy) is likely to be with a dermatologist. So the dermatologist has to be responsible to provide technical support, including training (over-diagnosis by the non-trained is well known) to the personnel in the on going integrated leprosy control programme, manage difficult clinical problems and complications at the leprosy referral centres (LRC) as recommended by NLEP and as part of the WHO Global strategy for 2006–2010 for leprosy control. In the meantime, research should continue (in collaboration with the dermatologists) to study the dynamics of transmission and for accelerated development of better chemo or immunotherapy so that the duration is further shortened. Early detection of nerve damage and methods (clinical and immunological parameters) which could be predictive of nerve damage should have the priority. A new and integrating link between *Mycobacterium leprae* and nerve degeneration was suggested in an earlier issue of leprosy review. Development of tele-leprology and efficient networking may be very useful in diagnosis and management. In Sao Paulo city, there is already a good programme running.

It can be safely stated that after committed leprosy workers and leprologists have reduced the numbers to a manageable level, the dermatologists in the emerging scenario should continue doing their bit to train paramedics and medical officers to help them pick up cases at the primary health care level. Deficiency in the training of medical officers managing the integrated programme in India and Brazil has been highlighted in an earlier issue of *Leprosy Review*. Dermatologists have also been required to provide expertise at various levels of competence to provide ‘sustained integrated quality leprosy control activities’.

The campaigns against leprosy have been largely successful. Final victory in the fight against leprosy should only be declared when there are no persons to be cured, no more discrimination and human rights violations to overcome and when persons once affected by the disease can lead normal, integrated and empowered lives with the same opportunities, rights and duties, as their fellow citizens (Delhi Declaration of Dignity, 2005). To achieve final victory of its eradication, efforts should continue both at the research and the level where the action (patient) is.

It is difficult to estimate what the dermatologists have contributed for leprosy control in the past, but it is obvious that they will be expected to continue to do so rather with greater zeal in the ‘post-elimination era’. It is entirely appropriate that this issue of *Leprosy Review* should be devoted to their role in the post elimination era and to avail of the occasion to extract enhanced commitment from the dermatologists for the cause so that leprosy becomes a part of history and our memories.

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