Rechristening and probably rediscovering the role of dermatologists in the post-elimination era is the major feature of this issue. The dismantling of the vertical programme for management and control of leprosy has come not as an unexpected development, but it indeed has been a shock to some. Almost everybody, the paramedical workers, leprologists and even the patients, seemed to be happy with the vertical programme. The dismantling began probably with financial pressure from the funding agencies to hurry up the cleaning process. Then came the numerical pressure because the number of patients had declined to the considered safe and arbitrary figure of less than 1 per 10,000 population, but the overriding factor was the impatience of the National Governments to derive as much political advantage they could by declaring elimination of another dreadful disease. All these factors individually or put together paved the way for the National Governments to integrate leprosy control programme with the already overcrowded, rather poorly run general health services, and thrust it on the not so willing and not properly trained staff. Rumblings were heard from all quarters, more so from the leprosy specialists, dermatologists, epidemiologists, microbiologists and those concerned with the transmission dynamics of the disease as new cases were still coming in not so insignificant numbers. Everybody had a point, new case detection rate had not changed significantly (to the discomfort of all), there were still pockets of high endemicity notably in India, Brazil and parts of Africa (including those with histoid disease) and for a disease with long incubation period, it could not be simple mathematics, dividing the total population by the number of patients. Repeated changes in definitions, duration of therapy, extension of deadlines and methods of registration irked many. The unsatisfactory state of the integrated programme regarding training and logistics were known to all which supported the views that integration was ‘premature’.

But as the governmental decision of integration with the general health services was irrevocable, the debate started as to who would/should or who can be charged with the responsibility of caring for this orphan disease and various constituents of the control programme, viz. diagnosis and treatment, management of the complications, prevention of disabilities, relapses and even drug resistance. With the resultant scarcity of the leprosy experts (after the dismantling of the vertical programme), the consensus seemed to rest on the dermatologists as the first point of contact for a patient with skin lesions. The dermatologist had teaching of leprosy as part of the curriculum and so had seen and treated leprosy. The stage for integration and transfer of responsibility from WHO, governments and NGOs having been set, it was thought prudent to get as much information as was possible from all those who were/are closely associated with leprosy through their contributions for the special issue. So the invitation to all to contribute to get more views and their impressions in the changing scenario and how do the dermatologists fit into it. Broadly, the views were on similar lines (by most of the contributors), in expressing satisfaction with the role of dermatologists, reiterating its continuation. They have important suggestions on what the dermatologists need to do to improve their participation and contribute more to the training and sensitization of the persons who have been chosen to take care of the leprosy patients. They should also try to remove the stigma of the disease by examining all the patients with skin lesions (including leprosy) with the same degree of concern and attachment and leprosy patients should definitely not be treated as children of a lesser God. Many still do fear that leprosy will become a neglected disease by the indifference of the governments.

Noordeen and da Costa Nery et al. felt that this debate on the role of the dermatologists is due to the changed scenario as the single disease super-specialist has no place in the public sector, as nobody was likely to benefit greatly from the ownership of leprosy and as there were actually no claimants so the
Dermatologists have been looking after leprosy and hopefully they would continue to go on reducing the burden and sustain the leprosy control programme. Some were more emphatic in their statements. Porichha was very patronizing in saying that ‘the disease has returned to its original stake holder’. Unfortunately, this happens at a time when there is less money and less interest in leprosy and dermatologists are increasingly moving towards more fashionable and money earning fields such as cosmetology.

The dermatologists should continue their efforts to try to solve the riddles of diagnostic criteria, define relapse and transmission of infection. The dermatologist looks at a patient as an individual and so may not follow the public health or epidemiological approach or even the national guidelines for treatment of the disease. That is how the ROM schedule could not convince them and was ultimately abandoned. Chandra also agrees that for individual patients it is the customized treatment and not the mass approach which is followed by the dermatologists.

Sharma feels the need for more stress on teaching leprosy to under- and postgraduates. It is indeed heartening to know from Oliviera et al. in Brazil, 72% of the medical institutions were devoting enough time to teaching of leprosy and the Brazilian Society of Dermatology has a website which provides virtual learning in leprosy. However, even in some leprosy endemic countries the teaching is fragmented.

Sharma, and also Pandey, felt that with the disease becoming rarer–missing of the diagnosis at first encounter may lead to a delayed diagnosis, with subsequent development of complications. For the same reason, Thappa et al. stressed the obvious need for appropriate training. Faye et al. pointed out the significance of appropriate training of the paramedics and medical officers. Imparting of ‘dermatological skills’ to primary health care workers in Mali (both in the rural and urban areas) did sharpen their diagnostic skills. Importance of the training cannot be underestimated because up to one third of the patients do not satisfy the diagnostic criteria based on the cardinal signs. Kar states that due to the lack of appropriate training and in the absence of these clinical signs it is unfair to expect at the primary health care level (PHC) level for somebody to diagnose and treat reactions, suspect relapse and take the decision to refer and coordinate with the neurologist, ophthalmologist and reconstructive surgeon so the enhanced need for the coordinator (dermatologist).

If we return to the earlier years and trace the history of association between the dermatologists and leprosy, Oliviera et al. in Brazil bring us to 1920 when in the care and control of leprosy the dermatologists were actively involved. Ryan informs us of the interest the dermatologists in UK had in leprosy and the great contribution they made in the areas of research, some even at the risk of losing their identity as dermatologists to be labelled as ‘leprologists’. Ryan also informs us that even the International League of Dermatological Societies has an award given annually to an eminent leprologist.

It is also suggested that the ‘community dermatology initiative’ may be more helpful not only for leprosy but many other distressing ailments. Ganapati et al. report about the great cooperation they received as an NGO from all concerned during their care of urban leprosy and that their concept of urban control would be suitable for the other major cities of India. They believe that NGOs have an important role to play in implementing the National programmes in an integrated manner.

Pandey from India and da Costa Nery et al. from Brazil advise the dermatologists to pick up public health orientation and combine preventive and curative aspects like what has been recommended in health services in Colombia and Brazil. We must take a note of the suggestions by Athreya and Oliviera et al. that the dermatologists because of their experiences should involve themselves more in policy making, developing curricula and delivery of services. Kawuma advises policy makers and health administrators to take advantage of the expertise of the dermatologists to redesign leprosy control strategies.

The suggestion of WHO and the National governments to set up the Regional Referral centres also has been echoed by Bianconcini et al. This needs to be viewed with the observations by Pandey that even after integration, most cases in many parts of India and Sri Lanka were being diagnosed by the dermatologists or vertical staff. Thappa et al. are convinced that the complications can be managed better by the dermatologist.
So, dear dermatologists, the disease was taught to you and you handled it like any other disease in the past not for any pecuniary interest but as a calling and everybody expects that you would continue to do the same with greater enthusiasm now that the responsibility for the final push for elimination of leprosy has been entrusted to you.

The good words from all the contributors are probably the greatest reward for what you did for the cause of the disease and its sufferers. It is rather easy to dwell on the successes but the needs of the ‘cured’ patients who still suffer the consequences have to be taken care of.

Health administrators please ensure that the over enthusiasm does not lead to complacency and ultimate despair. The efforts should be to eliminate leprosy and not the efforts against the disease. The dermatologists can easily handle the trickle but not the continuous stream.

Let the experts, readers, society and the patients judge the renewed involvement of the dermatologists and decide about the extent of their contribution in the ‘post-elimination era’.

Happy reading!

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