Role of dermatologist in leprosy elimination and post-elimination era

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India is a country where leprosy has been endemic for many decades. There is no doubt that due to concerted efforts of dedicated dermatologists and leprologists,\textsuperscript{1,2} it has been possible to reach the target of elimination in the year 2005.\textsuperscript{3} In India, leprosy services have been delivered through specialized vertical setup for about 50 years.\textsuperscript{4} However, in the post-elimination era, with a low prevalence of disease, as a part of the global strategy, leprosy services have been integrated within the existing vast infrastructure of the General Health System (GHS). This is now the well-accepted strategy to provide leprosy services in a cost effective, equitable and sustainable manner.\textsuperscript{5,6} In the Indian scenario, it means availability of diagnosis and management up to Primary Health Centre (PHC) level and MDT availability for treatment continuation up to Sub Centre (SC) level, on all working days of the week.\textsuperscript{7} In this setup, PHC Medical Officers who are to undertake diagnosis and treatment initiation, play a very crucial role. It has also been well realized that even after elimination for many years to come, new leprosy cases will keep coming as disease transmission is still a continuing process in the community.\textsuperscript{8–10} Now the question is, are our Medical Officers capable and confident in diagnosing the leprosy cases without much supervision and support, just by undergoing a short training of 3 days? Although the diagnosis and treatment criteria have been very simplified and standardized,\textsuperscript{11} our experience tells us that a large proportion of cases are still wrongly diagnosed\textsuperscript{12} or missed by the PHC medical officers.\textsuperscript{13} This is mainly due to the inherent characteristics of the disease. We know that just absence of cardinal signs does not rule out the possibility of leprosy, considering further the varied and many times atypical presentation of cases.\textsuperscript{14–16} Leprosy is a great mimic and confuses many times even the experienced leprologist.\textsuperscript{16,17} Many cases present only with nerve involvement.\textsuperscript{18,19} Few others are more prone to silent nerve damage.

Then there are problems of lepra reactions and unusual drug reactions,\textsuperscript{20,21} where views of trained dermatologist carry utmost importance. Treatment of the disease is also an enigma.\textsuperscript{16} Although we have fixed duration multidrug therapy (FD-MDT), many cases still require review and judgment at regular intervals from an expert.

When we cast our attention towards the condition of our Medical Officers in the PHC system, then we observe that they are always hard pressed and short of time. Moreover, we
have so many problems with a higher priority than leprosy, such as malaria, TB and HIV. Hence our attention and resources are being diverted to these priority diseases and leprosy is now gradually slipping away from the sight of health administrators. Our health system has already started losing the interest and motivation required to diagnose and treat the leprosy cases. Reasons may be many. Firstly, the disease requires thorough and elaborate examination, which is difficult to afford for PHC Medical Officers who often have an excessive burden of other cases. Hence, many cases may go unnoticed, leading to increasing time lag between the actual start and the detection of the disease. This leads to increased disease transmission and thereby a number of hidden cases in the community. It is relatively more difficult to validate the cases missed by PHC Medical Officers as it involves examination of large number of community members. Further active search of cases is against the current guidelines of Government of India. Delay in diagnosis has its own setbacks, as has been reported in a low endemic country such as the UK. We should not forget that although it has been eliminated, leprosy is still a threat to us. Moreover our past experience in a disease like malaria has taught us that over-enthusiasm may lead to despairing setbacks. Secondly, even if medical officers have time, many of them are not confident in diagnosis, which may be due to a fear of making a wrong diagnosis. This problem seems to be aggravated with declining number of cases and cases presenting with unusual clinical features. In the health system, there is a regular turnover of health personnel, and new Medical Officers are regularly recruited who may not have the experience required to examine and treat leprosy cases. Experiences from different Indian states like Orissa and Himachal Pradesh and the neighbouring country of Sri Lanka show that even after integration, most cases are still diagnosed by dermatologists or vertical staff. In African countries also, dermatologists have been identified as the most suitable people for diagnosis and management of leprosy cases in an integrated setup. Thirdly, there still seems to be some aversion and apathy to handle leprosy cases among PHC Medical Officers due to social reasons. Sensitization of the health system is a time taking process and it still continues. Critics have already expressed their apprehensions about loss of quality and technical expertise in delivery of leprosy services in an integrated setup.

Therefore, keeping the above scenario in mind, it needs no emphasis that dermatologists will continue to play a significant role even in the post-elimination era. However, we need to use their services judiciously, in a need based manner. First and foremost, we require an effective referral system, which is also an important component for the strategy to further reduce the burden of disease during 2006–2010. Of course, this referral system is to be built up within the existing GHS set up. The services of dermatologist can be made available at the first referral institution, which is a Taluka or district level hospital. Medical officers at PHC can screen and send only the needy cases requiring care of an expert dermatologist to these referral institutions. Secondly, these Dermatologists can regularly validate a sample of leprosy cases diagnosed by the Medical Officers of each PHC under the referral institution by undertaking regular supervisory visits. During these visits, they can also impart on-the-job training to Medical Officers and guide them in dealing with the problematic and difficult cases in a better way. This will not only help in maintaining the quality of diagnosis but also improve management of leprosy related complications such as the lepra reaction, drug reaction and the related sequelae such as deformities and even relapses. Such type of on-the-job training will be much more effective than the 3-day training schedule most of the medical officers undergo. There is no dearth of studies which have underlined the importance of effective training. This will also reduce the possibility of wrong diagnosis. Wherever there is
shortage of dermatologists, as in an Indian state of Chhattisgarh, the help of Medical Officers having long expertise in leprosy may be required. However, in the changed situation, public health orientation of the dermatologist will be vital for the ultimate success of the programme. Combination of preventive and curative services has been recommended by researchers evaluating impact of decentralization on leprosy control in Colombia and Brazil. Further, there is and there will be a dearth of qualified dermatologists in the country and the knowledge that majority of dermatologists are urban based and have their own private practice, it will be worthwhile to consider some kind of Public–Private Partnership initiative (PPPI) and involve them in some way for diagnosis, treatment and training related with leprosy. However, we need to regularly update knowledge of these private practitioners by providing them the latest guidelines and strategies of the programme. Lastly but not of least importance is the issue of technical supervision and monitoring, which is very essential but is not always followed effectively. We can also involve these dermatologists in regular monitoring of PHC activities during their supervisory visits. This is very much needed in critical post-integration phase to maintain the achievement made after years of dedicated work and for sustaining quality of available services.

Hence, it can be concluded that historically the dermatologist have played a leading role in leprosy control. However, in the changed scenario they still have a lot to offer albeit in a modified way with orientation towards Public Health.

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Dermatologist’s role in leprosy elimination/post-elimination

Dermatologist’s role in leprosy 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