Role of dermatologists in leprosy elimination and post-elimination era

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Summary Would it not have been better to have left out the word ‘elimination’ altogether in the question and do what WHO has done in its new strategic plan for 2006–2010, ‘Global Strategy for further reducing the Leprosy Burden and Sustaining Leprosy Control Activities’? Why not use a title such as ‘The Role of Dermatologists in reducing the Leprosy Burden and Sustaining Leprosy Control Activities’? Some elements of the ‘foundation’ of the elimination policy have been (and are still) very controversial, its definition and the unsubstantiated (up till now) claim that when reaching a prevalence rate of less than 1 per 10,000, the transmission of the infection would be interrupted and the incidence would therefore decline.

Role of dermatologists in leprosy elimination

If we understand this statement, this refers to the specific role of dermatologists in leprosy control. One has to remember, that in some countries, especially French speaking countries, and also in Holland, for example, leprosy and leprosy control were always part of the domain of the dermatologist. In countries with an ‘English; derived system (but also Brazil, Indonesia and Thailand), leprosy control is under the responsibility of Communicable Disease Control Departments and the dermatologists are ‘only’ assigned a role in the clinical aspects of leprosy. In the past, in Brazil, leprosy control was under the National Sanitary Dermatology Section, presently under the National Elimination Programme.

One often sees the elimination policy confounded by statements such as: ‘leprosy is a simple disease, which can easily be diagnosed and treated by general health staff’. A majority of new patients can indeed be ‘easily’ diagnosed and treated by general health staff. However, up to 30% of new patients may not have loss of sensation of the skin lesions, especially when they are towards the lepromatous end. This group of patients will need skin smears for diagnosis and some will present with more uncommon signs and symptoms. Many patients (up to one-third of patients, especially borderline and lepromatous) will present with reactions and other complications requiring special care. Management of these complications must include actions to prevent or minimize disability and provide adequate physical and social-economic rehabilitation.

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Leprosy has to be seen as a systemic disease, involving not only skin and nerves, but also many other organs. The role of a dermatologist in case of leprosy cannot be restricted to the part of the skin and diagnosis only, but must include the recognition, diagnosis and treatment of reactions and other complications. The treatment and management of severe reactions is not straightforward and must consider for example the serious side-effects of long-term treatment with corticosteroids. The dermatologist involved with leprosy also needs to have a public health understanding and vision of leprosy, so they can effectively collaborate in developing an effective leprosy control programme. Not all dermatologists are interested in public health and a ‘holistic’ approach is required from dermatologists working with leprosy.

**Role of dermatologists in post-elimination era**

Even now in many endemic countries, only a minority of dermatologists work with and are interested in leprosy and even fewer are involved directly in leprosy control. There are even some who actually refuse to have anything to do with leprosy. An interesting issue particularly when one of the objectives of the elimination strategy was to reduce leprosy stigma! In situations in which leprosy will be (or is already) a rare disease, one may not expect that this attitude will suddenly change for the better. Even now when leprosy is still a ‘common’ disease (at least in Brazil), ‘obvious’ diagnoses of leprosy are sometimes missed even by dermatologists, especially in case of the more uncommon presentations of lepromatous leprosy.

In low endemic areas, most patients with non-healing skin lesions will end up being attended by a dermatologist (if accessible to the – rural poor). Some patients because of specific symptoms mimicking other diseases or with neurological deficits and deformities will frequently be seen first by other specialists before being diagnosed with leprosy. Dermatologists will have to play an important role to act as a ‘safety-net’ for those patients ‘missed’ by the other health services in addition to providing technical support to referral and support services in leprosy management and control programs, and providing special care to persons with reactions and other complications. Dermatologists will continue to play an important role in teaching about leprosy and training of health service staff to identify and treat the disease adequately.

Most likely, in many countries leprosy will soon be classified and grouped under ‘rare diseases’ and often the diagnosis of leprosy will be a surprise finding. In such situations, it is difficult to predict if governments will maintain a structure for a leprosy control programme. Whatever will be, it is obvious that dermatologists have a role to play in further reducing the leprosy burden and sustaining leprosy control activities.

It is of great concern that such a statement about the (future) role of dermatologists in leprosy control could even be considered controversial and made a topic for a special issue of *Leprosy Review*. 

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