Histoid leprosy as reservoir of the disease; a challenge to leprosy elimination

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In the month of January, 2006, India was declared to have eliminated leprosy. In an article by the Director General of Health Services, Government of India, the graphical representation of the progressively decreasing prevalence rate and new case detection rate for leprosy was quite encouraging and the goal of elimination by December, 2005 was supposed to be in sight. However, as dermatologists, from our day to day experience in dealing with the patients with leprosy, it was rather difficult to accept this contention.

Histoid leprosy is an uncommon form of multibacillary disease, characterized by distinct clinical, histopathological, bacteriological and immunological features. It is quite rare and mostly occurs among patients with leprosy who had received dapsone monotherapy in the past. However, it was reported in previously untreated patients, as a manifestation of relapse several years after effective completion of an adequate course of MDT and in HIV infected patients with severe immunosuppression. As the bacillary load is very high in these patients, they can form a potential reservoir of the disease. While reporting a patient of histoid leprosy presenting as relapse following complete and effective MDT, it was appropriately stated by Ebenezer et al.: ‘occurrence of such cases reminds us that the road to elimination is not an easy one.’

Continued occurrence of histoid leprosy in areas of low endemicity and in areas from where leprosy has been declared as eliminated as in the state of Karnataka is a matter of concern. Moreover, the authors have been diagnosing histoid leprosy regularly (13 cases in 9 years) in their leprosy clinic in a smaller town of Karnataka, Bijapur, even though the total case load is not very heavy (Table 1).

New cases of histoid leprosy turning up even in areas of low endemicity leave us in doubt, and raise few pertinent questions:

- Was adequate care taken of issues such as ‘drug resistance’ and ‘relapse’ before declaring that ‘India has achieved the target of elimination of leprosy’?
- If the picture has not altered much in a small area of a low-endemic state, what must be the true situation in high-endemic states?

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Is that day far when each case harbouring drug-resistant bacilli will act as the source for many new leprosy cases?

It seems that national and international bodies are in extreme hurry to clean up the disease and their hands. The reported sharp decline in PR from 3.2 (March, 2004) to 1.3 (March, 2005) was considered to be due to ‘deliberate under detection of cases during the year 2003–2004 by the over-zealous staff due to pressure at all levels to achieve elimination by 2005.’8 Unfortunately, the pressure is not only to ‘under detect’ but also to ‘under treat’. With the current control policies being taken up by a group of people who have overlooked the fact that leprosy is a disease with a long incubation period and further considering the unidentified/unquantified patient load, a date bound elimination may not be wholly scientific and justifiable.

Even after the official elimination of leprosy the duties of the dermatologists to the disease leprosy and its sufferers will not be over. Though the leprosy control programmes have been merged with general health care the focussed attention of the specialist is still crucial. The dermatologists will have to go on picking new cases, treat debilitating reactions, educate on the care of deformed hands and feet, pare the trophic ulcers and console the sufferers that leprosy is ‘curable’. We as dermatologists will continue to strive and serve to make this world free of leprosy.

References

Dermatologist’s role in leprosy elimination/post-elimination


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