Role of dermatologists in leprosy

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The issue of the role of dermatologists in leprosy is being discussed increasingly in the recent past largely as a result of the changing scenario with regard to the disease. The changed situation in many parts of the world and particularly in India is that there are far fewer cases of leprosy to deal with as a result of the success of MDT and the leprosy elimination strategy pursued by leprosy endemic countries, with the active support of WHO and NGOs over the past 15 years or more. In public health terms, leprosy is a much smaller problem now than ever before. However, the new situation of having to deal with a smaller number of cases has thrown newer challenges as well as newer opportunities.

Even as the leprosy elimination strategy was yielding good results the need for leprosy to be part of the general health service and general medical care was increasingly felt. This led to the increasing emphasis on integration of leprosy within general health services. While this integration approach is both logical and cost-effective, several issues related to patient care have come up which need to be addressed.

Among the several issues the most important are (a) how do we maintain the needed skills at the peripheral or primary health care level to diagnose and treat leprosy accurately, (b) how do we deal with complications that need both the expertise as well as facilities for hospitalization and (c) how do we deal with problems of disability that need both surgical and other rehabilitative support.

With these challenges in mind one can look at the emerging opportunities that might help in addressing them. In the past leprosy was part of the dermatologist’s portfolio and they did deal with leprosy patients as and when they came to them. However, the existence of a more specialized group with the name of leprologists made many patients seek the help of such single disease super-specialists. This was further reinforced by the fact that leprosy was essentially in the domain of public sector. This well justified domination of the public sector was due to (a) leprosy being an important public health problem, (b) leprosy involving a huge number of patients particularly in countries like India, (c) leprosy being considered as a very complex disease and (d) leprosy not being in the mainstream of medicine and medical care as a result of widespread social stigma. Lastly it should be added that leprologists themselves contributed to certain myths and mysteries of the disease as if no one other than themselves can handle the disease. However, it must be added that a significant number of dermatologists took a strong interest in leprosy and made valuable contributions even if such contributions were confined to clinical activities.

Today the leprosy situation has greatly changed. In most parts of the world, currently leprosy is not considered to be a serious public health problem. Secondly, the absolute
number of cases, as well as the rate of occurrence of the disease, has come down so steeply that even specialized institutions for leprosy are not having enough patients to deal with. In addition it is increasingly recognized that by and large diagnosis and treatment of leprosy is relatively less complex than what was thought to be and that there is no compulsive need for the highly specialized leprologists except in some special situations. Further the stigma against leprosy is steadily decreasing everywhere and leprosy is increasingly accepted within general medical care. Lastly with the proportionally decreasing number of leprologists there is less vested interest in leprosy and even less discussion on ‘ownership’ of the disease.

Under the circumstances and as discussed above, it is clear that the remaining tasks of dealing with leprosy, particularly with regard to patient care at the specialized level, will have to be borne more and more by dermatologists. However, such care should not be confined to tertiary care hospitals as has been hitherto but move towards secondary care centres and first level referral facilities of primary health care. This presupposes a level of development in dermatological services further down the health care chain. If all first level referral facilities of primary health care as well as the secondary care hospitals have dermatologists it should be possible to provide quality services for leprosy patients particularly in problem situations. Whether or not such percolation of dermatological services will take place remains to be seen. In addition dermatologists in private services can also contribute to qualitative care in dealing with the remaining leprosy problem. Over a period of time a degree of verticalization in dealing with leprosy patients mostly through specialized services may become inevitable.

A note of caution is necessary while considering the role of dermatologists in that leprosy is not only a dermatological condition. It has significant neurological, orthopedic, ocular, and rehabilitative components apart from others. Therefore, a holistic approach towards leprosy will still be needed. However, there is no alternative to dermatologists playing the key role and taking up the leadership for solving the remaining problems in leprosy.