This issue of Leprosy Review should be landing on your desks in better time than last month’s. We now have a new printer and hope for a smooth process.

We have some important papers in this issue. Many people will be interested in the survey of leprosy cases in Maharashtra, West India undertaken by Vanaja Shetty and colleagues in September 2007 (p. 22). They did active leprosy surveys using house to house surveying in two districts, one urban and one rural in Maharashtra. They found prevalence rates ranging from 9.42 to 2.96 per 10,000 population and 1.9 to 6.8 per 10,000 in the urban areas. This contrasts with the reported prevalence of 0.9 per 10,000. These were newly diagnosed cases and all were confirmed. Another significant finding was that of the single skin lesion cases that they identified 12.5% had BB–BL disease on histological examination. This suggests that there is a large pool of undiagnosed cases. Most of the patients had not received health education about leprosy and did not know what the disease was. This lack of knowledge means that patients cannot be expected to come forward voluntarily for treatment. This study, along with others from Bangladesh, shows that leprosy is still present at high levels in some areas. It is vital that we should be making active efforts to identify those areas where there are higher numbers of patients. Perhaps new diagnostic strategies are needed in these areas. Combining active surveys with mapping using GIS techniques might be useful in identifying such areas. This has been done with some success in Brazil. In April 2009 the WHO national programme managers will meet in Delhi, India, and this data is helpful in planning future strategies which will need to be imaginative and use new tools in a cost effective way.

Other studies have looked at optimising the measurement of nerve damage. Khambati and colleagues (p. 34) have looked at the sensitivity and specificity of different tests of nerve function with nerve conduction studies as the gold standard. They found a high rate of new nerve damage in newly detected multi-bacillary patients. Testing sensation using graded monofilaments had a good specificity but only a fair sensitivity, indicating that nerve conduction studies detect more nerve damage and probably earlier nerve damage. However the optimal combination was by combining nerve palpation with Voluntary Muscle Testing and monofilament sensory testing. Another approach is to identify the minimum number of tests needed to identify people with new nerve damage. This was done by Van Veen et al. (p. 51). They reanalysed a data set looking at three different, simple ways of testing nerve function. They found that the simplest combination that would identify most patients with nerve damage was the ILEP test which tests four points for sensation on the hands and four movements using a three grade assessment. However all three tests that they assessed had substantial error rates of about 20%. So the ideal field friendly test for nerve function has not yet been identified.

In the review section we have two reviews, one a short version of the Cochrane review on surgery in the treatment of nerve damage. This is an important area because some surgeons are very keen on decompression for the treatment of nerve damage. However the reviewers found that only two trials were suitable for inclusion in the review. Even then there were only small numbers of patients with heterogeneous clinical findings in the studies. So for the moment the role of surgery in the treatment of nerve damage is ‘Not proven’. It may be that a small number of nerves may benefit but surgeons should link up to develop a multi-centre randomised study with sufficient patients and clinically relevant outcomes to determine whether surgery does have a role. It may also be that the nerves that might benefit are a small subset and need better definition using nerve conduction studies.
The other review is literature based and suggests that assistive devices for facilitating daily living are underused both in protective and facilitatory roles. This also highlights the often long term needs of patient who have been treated for leprosy.

Roland Kazen, the surgeon, died in January 2009. Roland was an inspirational surgeon and many people have benefited from his skills. Marcos Virmond has written a heartfelt tribute to a colleague and friend.

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