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LETTER TO THE EDITOR

Contact management is an essential component of leprosy control

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It is somewhat surprising that Lockwood and her co-authors take such a negative position against contact management in leprosy. Contact management is an effective method of early case detection; it provides counselling to those exposed, and information on how to report the early signs and symptoms of leprosy. The addition of chemoprophylaxis can significantly reduce the incidence of new cases in those exposed. Identification and examination of household contacts close to the time of diagnosis is recommended by the current (2011–2015) WHO strategy for leprosy[1] and the WHO Operational Guidelines[2] further recommends that such contacts be educated on the early signs of the disease and requested to report if any suspect skin lesions or motor or sensory changes occur.

Lockwood *et al.* state that many newly diagnosed cases are not related to known cases, although presumably they have all been exposed to a source at some point in time. The point here is that many undiagnosed cases are related to newly diagnosed cases and will remain undiagnosed without active contact management. The WHO Expert Committee report[3] notes that household contacts may contribute a significant proportion of all new cases specifically in situations of relatively low or moderate endemicity.

There are logistical, economic and ethical issues involved in contact tracing such as disclosure of diagnosis, workload and cost-effectiveness. The purpose of implementing pilot or development projects on contact management in different countries and in different settings is to explore effective solutions to these issues. Perhaps migrants and students in London are not particularly typical of the issues to be addressed in most leprosy endemic countries. However effective and acceptable approaches are being developed in many countries and national programme managers are encouraged to engage in these innovative approaches. The diagnosis of early leprosy is indeed a challenge. Staff training is an important component of these interventions. The development of new, diagnostics tests is a specific solution now being actively explored.

Lockwood calls for stronger scientific evidence for chemoprophylaxis but yet uses ‘unpublished’ and ‘under-powered’ studies to challenge a large, published randomised controlled trial (RCT). Pilot studies are developed with different objectives and designs from RCTs. These are designs used to explore logistical and ethical challenges and to develop solutions which can be scaled up in specific settings. It is important to recognise the different study designs and the different objectives. Evidence based medicine recognises the hierarchy of evidence and uses critical appraisal in the process of systematic reviews and meta-analyses. Systematic review methods should be used when assessing the evidence of effectiveness of chemoprophylaxis.[4]

Finally, post-exposure prophylaxis (PEP) only implies that the prophylaxis was given after exposure as opposed to pre-exposure, such as BCG at birth, and is the appropriate term. Effective leprosy control requires early diagnosis and prompt multidrug therapy for all patients, tracing and post-exposure

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prophylaxis for contacts of patients newly diagnosed with leprosy, improvements in diagnostic tools, as well as strict epidemiological surveillance and response systems to monitor progress.

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