Editor’s Choice

This issue of Leprosy Review has our customary wide range of articles covering many aspects of leprosy.

We start with a commentary by June Nash on leprosaria. I invited her to write this in response to the paper by Shen et al. (p 281) about the current status of leprosaria in the People’s Republic of China. Their survey showed that there are currently more than 18,000 people affected by still living in colonies. If their dependents are added in this represents a large number of people living in colonies. The survey showed that 72% of the residents had grade 2 disability and 47% were unable to care for themselves. This shows that there continues to be a very high burden of disease associated with leprosy patients, many of whom were treated long ago but have been left with needs that the health services should cover. Shen et al. found that the leprosaria were located at remote places and with buildings close to collapse. The medical and social infrastructure supporting the leprosaria was also very weak. Shen et al. suggest that the leprosaria should be relocated and reconstructed to provide new centres for leprosy. This would have the benefit of keeping leprosy on the public health agenda and placing them in better contact with mainstream medicine. June Nash looks at the history of leprosaria, pointing out that some of the best research took place there, but she also expands on the role of the patients within the leprosaria. Patients placed in leprosaria suffer the problems of institutionalisation and isolation. Formerly they were often placed here against their will. Even today old leprosaria patients are often not properly consulted about their needs or wishes. In some countries patients’ organisations have promoted a patients’ rights agenda but this is unusual. Leprosaria around the world are being closed and this produces challenges around integration of patients back into society and how best to provide good care for this now elderly population who need gerontologists rather than leprologists looking after them. What is critical is to involve the patients in decisions about their future. I hope that this pair of articles will stimulate discussion.

Every leprosy control programme I have ever visited, even in remote Ethiopia, has wall maps of the area the workers cover to guide their travels. But we can do this better electronically with Geographical Information System (GIS) mapping. De Souza Dias et al. (p 261) report on using GIS mapping to plot out the location of patients in a municipality in NE Brazil. By mapping the homes of patients diagnosed with leprosy over the last 4 years they were able to show where the highest concentrations of leprosy patients were. They then used this information to guide their case finding and diagnosed 104 new cases. This is an exciting new tool that can make case finding more targeted and cost effective.

There is very little information on the incidence of adverse effects in patients taking multi-drug therapy (MDT), surprisingly these have never been looked for systematically or reported in any of the drug studies that were done around the time of introduction of multi-drug therapy. Deps et al. (p 216) report on a retrospective cohort of patients in Brazil taking MB-MDT and found that 45% of patients had an adverse effect attributable to MDT and 24% stopped one drug. Although dapsone was the main culprit, rifampicin accounted for a significant proportion of the adverse effects. Why has this not been reported before? It may be that clinicians became familiar with the profile of adverse effect due to MDT very quickly and were able to warn patients about adverse effects. It may be that this high rate of adverse effects is peculiar to the Brazilian population. Firstly this study should be replicated using a prospective design; secondly it should be replicated elsewhere so that we have good data on which to advise our patients. A potentially very serious aspect of this high
rate of stopping one drug is that patients are then taking dual rather than triple therapy and there is a much greater risk of drug resistance developing.

A very important workshop on rifampicin resistance was held in Agra, India last year and it is a pleasure to reprint the WHO report (p 295) so that the discussion is available to all our readers. At the moment there is very little clinical evidence of rifampicin resistance. However there is some evidence that genes conferring resistance to rifampicin have been detected in *M. leprae* isolates. This highlights the importance of good global surveillance of *M. leprae*. There needs to be support for the small number of labs who are still growing *M. leprae* in mouse footpads and for the molecular biology labs that are developing molecular tools for detecting resistance genes. It is also important that there is close correlation of clinical information with the microbiological and molecular information.

Next January the 17th International Leprosy Congress will be held in Hyderabad, India and I hope that many readers of *Leprosy Review* will be there. In the next issue we shall be publishing a series of major reviews on the current challenges facing the leprosy community and I hope that this will help focus the agenda for some of the discussions at the ILC meeting about the future of leprosy work. However as the paper on leprosaria in China shows this is not a problem amenable to quick fixes.

*Diana NJ Lockwood*