DERMATOLOGISTS AND LEPROSY IN INDIA

Leprosy has been treated by dermatologists for over half a century. Teachers in dermatology in all medical schools and colleges were MBBS with three months’ training in leprosy in the School of Tropical Medicine. Advanced leprosy cases with deformity were treated mostly at leprosaria but also in medical colleges. In the control programme in India, which was in operation from 1954, under SET centres, only advanced cases or those with marked sensory loss were picked up by workers and given dapsone. The early cases or those with acute reactions were managed by dermatologists even at that time.

When the NLEP was established in 1983, dermatologists were side-lined as has been rightly mentioned by Sharma. The programme was wholly managed by public health people. The training programme, including clinical training, of the basic workers (non-medical assistants or NMAs) was also designed and implemented by public health doctors posted in the leprosy division. Unfortunately, people at the top too had no exposure to clinical leprosy.

This resulted in poor diagnoses and the missing of a large number of cases which today are conveniently referred to as ‘hidden’ cases. Only those cases were diagnosed by the NMAs who either had gross deformity, extensive sensory loss, or nodular leprosy. At the same time many non-leprosy cases were diagnosed and treated as cases of leprosy. Medical officers, few of whom had been trained for 6 weeks in leprosy, would seldom see patients. Their role would merely be of signing the patient cards of leprosy cases. If dermatologists would have been involved, the scene would certainly have been different. How can a person who has almost no clinical experience of leprosy or of skin conditions that need to be differentiated from it himself teach the NMA trainees?

Whatever has happened, has happened. Dermatologists had been committed to teach and manage cases of leprosy before the MDT era, so called elimination period and post elimination era. Dermatologists will continue to teach medical students about leprosy. Some public health people still feel that dermatologists cannot be expected to have an eye for nerve function impairment, in the sense of testing for sensory and motor loss and actively preventing development of disability. How far removed these public health people are from ground realities! They offer such comments and have such opinions without perhaps ever seeing a dermatologist at work. Unfortunately, they are the policy makers of various national and international health programmes.

People who have actually worked in the field feel a ‘great concern that such a statement about the future role of dermatologists in leprosy control could even be considered controversial and made a topic for a special issue of Leprosy Review’. This issue just shows that finally most public health epidemiologists have realised the indispensable role of dermatologists and their own limitations. We only wish they had appreciated this two decades ago so that the picture of leprosy today, at least in India, would have been different.

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References