

Re-examination of Discharged Leprosy Cases.

JOHN LOWE.

(Reprinted from "Leprosy in India," January, 1933.)

IF we are to form a true idea of the value of special treatment for leprosy, it is most important that we should investigate the matter of the permanence of results of treatment. This has been done in some countries with very varying results. In the Philippines a survey of discharged cases has shown about 37% of cases relapsed. In Hawaii a relapse rate of over 90% is reported. The relapse rate must vary because of varying types of cases, varying effectiveness and duration of treatment, varying standards for discharge

of patients and varying periods between discharge and re-examination.

In India, where leprosy treatment is entirely voluntary, we are often able to get cases for treatment at an earlier stage than is possible in some other countries, so our results should be better, but it is often impossible for patients to continue treatment long enough, and even if they continue treatment until discharge it is often impossible to get patients for re-examination after discharge.

In this brief note we produce some facts about a series of 84 cases discharged from the Leprosy Hospital, Dichpali, and re-examined after varying periods. This material is far from satisfactory. The 84 patients form only a fraction of the patients discharged during the period under review. It may be that under a voluntary system patients with signs of recurrence are more likely to come for re-examination than those who remain well. The period that has elapsed between the time of discharge and re-examination will, of course, markedly affect the percentage of relapses, as some relapses may be delayed for many years. In this series of 84 cases the period between discharge and re-examination varied between six months and four years, with an average of only fourteen months, far too short to justify final conclusions being drawn. Another point which should be mentioned is that owing to the great demand for admission of new patients we had to discharge old patients at the earliest possible moment. The standards adopted for discharge were (1) absence of clinical evidence of activity for six months, (2) absence of evidence of discharge of bacilli. (3) Residual bacilli if present in the skin in small number did not necessarily prevent the patients' discharge if the disease was clinically inactive. (4) Failure to react to large doses of potassium iodide. These standards are very much below the generally accepted standards, and were adopted for reasons of expediency, but all patients discharged were strongly recommended to come back for examination within six months. Some of the patients have done this and some have paid several visits at six monthly intervals, and the following data were based on examination of these cases.

For satisfactory estimation of progress, repeated clinical and bacteriological examinations are necessary. In this note, for the sake of brevity, we shall quote only the bacteriological report. Bacteriological examination was made of the nose by scraping and the skin by the clip method.

<i>Bact. Exam. before treatment.</i>	<i>On discharge.</i>	<i>On re-examination.</i>
Nose and skin showing bacilli .. 43 cases	0 cases	2 cases
Skin only showing bacilli .. 21 cases	*42 cases	40 cases
No bacilli found 20 cases	42 cases	42 cases

* These cases, though showing a few bacilli, were clinically inactive and were therefore discharged as explained above.

6 cases showed bacteriological evidence of relapse on re-examination.

6 cases showed clinical but no bacteriological evidence of relapse on re-examination.

12 cases in all showed evidence of relapse.

72 cases showed no evidence of reactivation of disease.

4 cases showing bacilli on discharge showed no bacilli on re-examination.

A few interesting points may be discussed.

Of 42 cases clinically inactive but showing a few bacilli in the skin on discharge, 10 showed signs of relapse. Of 42 cases showing no bacilli on discharge 2 showed signs of relapse. Comparison of these two classes shows that, if possible, treatment should be continued until no more bacilli can be found.

Four cases still showing bacilli on discharge, showed no bacilli on re-examination. This shows that improvement in some cases continues, in spite of treatment being stopped.

To most of the patients before discharge large doses (up to gr. 240) of potassium iodide were given, and if this was not followed by lepra reaction it was regarded as evidence of inactivity and possibly as an indication of there being less chance of relapse.

Of the 12 cases showing signs of relapse 11 had received potassium iodide without reaction before discharge. This indicates that the failure to react to large doses of potassium iodide is little guarantee against relapse, though on the other hand reaction to iodide may be a useful indication that further treatment is necessary.

Thus the percentage of cases showing relapse within an average period of 14 months is 14%, but this figure cannot be taken as indicating the percentage of relapses in the total number of discharged patients. These 84 cases were only a fraction of the total number discharged during the preceding years, and some of them came for examination because they suspected relapse, otherwise they would not have come.

(The length of treatment of these 84 cases before discharge varied from 6 months to 9 years, with an average of 2 years and 8 months.)