*LEPROSY CASES IN THE BRITISH ISLES

LEONARD ROGERS, J. HOWARD COOK, and E. MUIR.

At the request of the Medical Committee of the British Empire Leprosy Relief Association a subcommittee consisting of the three of us have carried out an inquiry into the number of leprosy cases seen during the last thirty years by dermatologists in all parts of the country. The following is an analysis of replies received to a circular letter which enclosed forms to cover the required information. These were received from fifty specialists, only fourteen of whom had seen any cases of the disease. The great majority were reported by Dr. J. M. H. MacLeod (to whom we are particularly indebted for his reports of cases) from the St. Giles Homes in Essex and private cases, and by two of us (L.R. and E.M.). All but six cases had been seen in London, doubtless due to so many patients from overseas visiting London for medical advice. The provinces therefore show very few cases, although no doubt there are some regarding which no information has been received. Concealment is likely to be less common than it was two decades ago now that it is generally known that treatment of value is available to those seeking it in good time.

TABLE I.—*Countries in which the Disease was Apparently Acquired (87 Cases)*

Europe: British Isles 4, Malta 1, Norway 1, Russia 1	7
Asia: India and Burma 35, Malaya 9, East Indies 2, China 3 ...	49
Africa: S. Africa 5, S. Rhodesia 1, Zanzibar 1, Nigeria 2, Egypt 1	10
Western Hemisphere: West Indies 5, British Guiana 4, Columbia 1, Brazil 2	12
Doubtful: "Abroard" 6, unrecorded 3	9

Countries of Origin. It will be seen from the data in Table I that no fewer than thirty-five of the seventy-eight cases regarding which information is available came from India, including Burma —doubtless owing to the large number of Europeans and to the high incidence of leprosy in that densely populated country. Malaya was next, with nine cases.

Cases Apparently Contracted in the British Isles. These number only four in thirty years, all of which were seen from eleven to twenty years ago, and were reported by Dr. J. M. H. MacLeod. In each of these there was prolonged close contact with a highly infective lepromatous case; one was a conjugal infection, and the other three patients were first seen when

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respectively 12, 15, and 18 years old, indicating infection at the early susceptible age. On account of lower susceptibility in adults conjugal leprosy infections are far less common, and we know of several highly infectious patients who have been faithfully nursed by devoted wives for a number of years in this country without transmitting the disease. No case is known to us of infection in the British Isles from a neural or a tuberculoid case, in which leprosy bacilli are very few and are difficult to find.

CLASSIFICATION OF THE CASES

In Table II the eighty-seven cases (after excluding duplicates returned by more than one spe
types and arranged to bring out the number still alive and resident in this country. These are subdivided into the little-infective neural and tuberculoid and the more dangerous lepromatous or cutaneous cases. Those styled "mixed" are included under the more infective lepromatous type, as bacilli may be numerous.

TABLE II.—*Cases of Leprosy seen in Recent Decades by British Dermatologists*

	Lepromatous and Mixed	Tuberculoid	Neural	Type Doubtful	Totals	
Former cases:						
1. Dead	16	—	7	—	23	47
2. Repatriated	6	—	7	—	13	
3. Last seen over 10 years ago	3	—	7	1	11	
Little-Infective living neural and tuberculoid:						
4. Last seen under 10 years ago	—	—	4	—	4	18
5. At present under observation	—	1	11	2	14	
Infective living lepromatous cases:						
6. At present under observation	18	—	—	—	18	22
7. Last seen under 10 years ago	4	—	—	—	4	
Totals	47	1	36	3		87

In Table II, lines 1 to 3 show respectively those already dead, those repatriated, and those presumed to be dead or to have passed into a little-infective stage. Those in Category 3 were last heard of from ten to upwards of thirty years ago. The presumption of death after that period is considered justifiable in patients of the lepromatous type, for no fewer than eleven out of thirteen such patients regarding whom information is available had died within one to eight years of being first seen. The whole of the cases in lines 1 to 3 may thus be regarded as no longer of any danger to the community.

Lines 4 and 5 show little-infective neural cases, including one with tuberculoid lesions. They are still alive, or presumed to be alive, because they were last seen less than ten years ago. In view of the fact above recorded, that no such case has been known

to cause infection in this country, they present very little danger to the British community, although in rare instances abroad neural cases have been known to pass into a more infective type.

Lines 6 and 7 each show infective lepromatous cases, those in the former line being known to be alive and in this country, and those in the latter being presumed to be alive as they have been seen within the last ten years. They number eighteen and four respectively, giving a total of twenty-two; they require further consideration.

LIVING CONDITIONS OF INFECTIVE LEPROMATOUS CASES

These are shown in Table III, which brings out the following points: Of the twenty-two, five were safely accommodated at the St. Giles Homes; of two more it is reported that one is " strictly segregated ' and the other is also isolated at home, ' keeping absolutely to himself and taking every precaution against dissemination " of his disease; in two more the disease has reached a quiescent and little infectious stage under treatment; four others were seen at the Hospital for Tropical Diseases, London, and will doubtless have received full instructions regarding the necessary precautions; and a further five are under the highly expert care and treatment of London specialists. In the remaining four the living conditions were not regarded as very satisfactory. The first was reported in 1929 to be residing in a flat with his wife and a young maid during an attack of leprotic fever. The second, a Eurasian subject, was living in the provinces unsegregated. The third was living five years ago with his wife and adult daughter, aged respectively 55 and 35. With these four exceptions the infective cases appear to be well cared for and of little danger to the British community.

TABLE III.—*Conditions of Living of the Infective Lepromatous Cases*

Isolated at the St. Giles Homes in Essex	5
Isolated with careful precautions at home	2
Reached a quiescent little-infective stage	2
Seen at the Tropical Diseases Hospital	4
Under expert care and treatment	5
Conditions unsatisfactory	4

CONCLUSIONS

We conclude from the above data that the present position is reassuring in view of the fact that nearly all the cases of the infective type are under expert care. Moreover, the danger of infection under the good hygienic conditions of Great Britain is much diminished by the fact that the great majority of the

repatriated patients are of a social position that permits them to live under favourable sanitary arrangements and to avoid overcrowding. Further, many of them have reached an age when they are unlikely to come into close and prolonged contact with children, who are considered particularly susceptible. We are, however, of the opinion that all infective lepromatous patients who are not in a position to carry out effective home isolation with absolute prohibition of close contact with children should, so far as is possible, be accommodated at the St. Giles Homes. If necessary, Government funds should be made available for effecting this purpose.