REVIEWS.

Promizole Treatment of Leprosy, by Faget, G. H., Pogge, R. C. and Johanson, F. A., *U.S.A. P.H. Rep.* 61, 957, (1946).

Promizole is the trade name for 2, 4'-diamino-5-thiasolylphenyl sulfone. Seven out of an original group of eleven patients were under treatment with promizole at the U.S.A. National Leprosarium for a year. The following conclusion was arrived at :

"No claim is made in regard to the ultimate value of promizole given orally in doses of 6 gm. daily in the treatment of leprosy. Attention is called to the fact that promizole is well tolerated by patients with leprosy, and that clinical improvement occasionally can be demonstrated more quickly with promizole than with similar sulfones, such as promin and diasone. It is felt that the therapeutic results thus far obtained are sufficiently encouraging to warrant further clinical study, which will be necessary before a final evaluation of promizole in the treatment of leprosy can be given."

A plate illustrates the rapid changes in lepromatous lesions of two cases after only 3 months.

Present Status of Diasone in the Treatment of Leprosy, by Faget, G. H., Pogge, R. C. and Johansen, F. A. *U.S.A. P.H. Rep.* **61**, 960, (1946).

Out of 104 patients selected, 63.5 per cent had received treatment for six months or more at the time of the communication. The authors' report as follows :—

"It would appear from our clinical observations that diasone has an action similar to that of promin, which has been reported in considerable detail. Treatment with diasone has the advantage that the drug is tolerated in doses up to 1.0 gm. daily for long periods of time. The number of patients in whom treatment was discontinued because of anaemia is low, because many of the patients receive liver or iron products with the diasone. The number in whom treatment was discontinued because of hematuria is limited to four patients, who were started with doses of 1.0 gm. daily early in the study. At the present time diasone is administered in doses of 0.33 gm. daily for the first 2 weeks, and then gradually increased to 1.0 gm. Since the adoption of this policy there have been no further cases of hematuria."

The progress of four of the cases is illustrated with very striking photographs.

Leprosy in Spain. A booklet recently issued by Dr. Felix Contreras Duenas deals with this subject. After discussing the nature of leprosy and its spread, and recording the history of the disease in Spain, he quotes the various authorities on the subject regarding the present incidence of the disease. In Andalusia there are said to be 2,000 cases, in the Levantine Provinces 1,300, and 600 in Galicia, or about 4,000 altogether, but he considers that this is an under-estimate and that the total number may be 8,000. There are also said to be 650 in the Canary Isles and 8,000 in Spanish Guinea. Of those in Spain proper, there are at present 210 in the leprosy hospital at Fontilles, in Alicante, and 178 divided among five smaller institutions. The author considers that for the 8.000 cases in Spain proper provision should be made for the institutional segregation of 2,000, and dispensary treatment for 5,000 closed cases, while 1,000 would be treated privately at home.

The Control of Leprosy among the Azande, Anglo-Egyptian Sudan. (1946), Bloss, J. E. F., *Trans. Roy. Soc. Trop. Med. and Hyg.* **39**, 423.

The writer reviews, after twelve years of anti-leprosy measures, the control of leprosy attained among the Azande people of the Anglo-Egyptian Sudan.

In 1929, while making a sleeping sickness investigation, a

survey of leprosy was also carried out in the Zande country, and 6,400 cases were found among a population of approximately 180,000, making about 3.5 per cent. Of these 5,500 cases were at first segregated in two leprosy settlements. It is remarkable that only 20 per cent of these were of the neural type, whereas in most highly endemic areas 80 per cent of neural cases would be more likely. Twenty per cent were under twenty. The leprosy settlements were placed with chiefs, with a part-time doctor in charge, but many of the patients deserted to their homes and only the worst cases remained. In 1935 there were 204 advanced cases segregated, 1,021 under observation and treatment in the settlement, 809 outside cases that had never been in the settlement, and 1,464 discharged cases living inside or outside the settlement. In 1942, 60 per cent of patients in the Li Rangu Settlement were neural cases, 54 per cent being N1 cases. In that year the total incidence is calculated as being very similar to that 12 years before, but the age incidence shows less than 12 per cent are under 20 years of age, and new cases among children are comparatively rare. The writer gathers from these observations that leprosy is now under control and on the decrease. He considers that the low protein content of the diet and the absence of meat due to the tsetse fly, is the chief cause of leprosy. [In this he differs from most recent writers on the subject, who tend to ascribe a secondary, though still important, role to diet.] He hopes that with economic development, the control of other endemic diseases, and improved education leprosy will tend to die out. While the large form of leprosy settlement is still necessary, it should be changed to smaller " chiefs " settlements as soon as education has had time to produce intelligent and full support from chiefs and people. This it is hoped " will come in the fullness of time, but to force it at the wrong time would cause chaos." [This policy may be necessary where sufficient suitable staff is not available. It is in very marked contrast to the method adopted, say, in the Owerri Province of Nigeria, where a similarly high incidence of leprosy is being used as a means to educate the community, improve the standard of living, and win the co-operation of chiefs and people, incidentally bringing leprosy under control.]