

## LEPROSY IN THE BRITISH WEST INDIES.

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At the request of the Medical Adviser to the Controller for Development and Welfare, I visited Jamaica, Trinidad, British Guiana, Grenada, St. Lucia and Barbados in April and May, 1948. The object of the visits was to investigate leprosy in these colonies and advise regarding its treatment and control. Short reports were prepared after investigations in each colony and submitted to the local governments and the Controller. These are here abstracted and condensed. Reference may be made to reports of previous visits.\*

Leprosy in the British West Indies (including British Guiana) must be studied from the background of the whole Caribbean Area, in some other parts of which the disease is much more prevalent than in the British Colonies themselves.

Leprosy is not a problem of major importance in the British West Indies. There is however a growing feeling that just on that account it should be eliminated, if that can be accomplished without unduly depleting resources required for other more serious and urgent health problems. The highest prevalence is in Trinidad and British Guiana, in each of which there are calculated to be 1000 or more cases (0.3 to 0.4 per mille), but in Jamaica and in the smaller islands (Leeward, Windward, Barbados) it is considerably less.

Leprosy is associated with a shifting population. In the settled village everyone knows everyone else, and anyone suffering from leprosy is likely to be avoided by his neighbours, though he may infect his own family. But in a shifting population, especially the labour personnel of large industrial concerns (oil fields, sugar factories, etc.), everyone rubs shoulders with all and sundry, and the spreader of infection is less likely to be recognised and avoided.

Also those who go abroad, either for work or to visit relatives, not infrequently unconsciously contact infectious cases and acquire the disease. This was particularly seen in St. Lucia, where the majority of cases had been in direct or indirect contact with French Guiana, a country where leprosy is particularly prevalent.

## SULPHONE TREATMENT.

There is reason to hope that the whole question of the control

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\* *Leprosy Review* (1942), 13, 22; (1943) 14, 4, 18, 25, 29, 33, 39; (1944) 15, 35, 40, 43.

of leprosy will be considerably modified by the introduction of sulphone therapy.

I spent four years (1941-1945) as Medical Superintendent of the Trinidad leprosarium, but it was only during the last seven or eight months of that period that the patients were on sulphone treatment. I found on my return after three years absence that many patients who, under the pre-sulphone regime would have been dead, blind, bedridden or permanently disabled, were now stronger and healthier, engaged in active work, and making obvious progress towards recovery. Lepromatous ulcers, once so common, had now almost entirely disappeared, and even trophic lesions had greatly diminished.

In the Jamaica leprosy institution the change for the better was also very noteworthy. Lepromatous ulcers caused by the breaking down of nodules and thickened skin lesions, formerly a marked feature, were absent, though the scars could still be seen. Also the distressing conditions of the nose and throat were absent, as were to a large extent those of the eyes. This was undoubtedly due to the introduction of sulphone treatment only nine or ten months before. The results were the more surprising as a shortage of supplies had interrupted the treatment for one or more months at the end of 1947. Of over 90 active cases of the malignant (lepromatous) type on promin or diasone treatment, 35 showed marked improvement in healing of ulcers, flattening of nodules, and clearing up of the nose and throat. In 30 others there was a distinct, though less marked, improvement. All these patients felt considerable improvement in general health. In several cases progressive deterioration of the eyes had become arrested.

An important fact is that the treatment in Jamaica was carried out by the Sisters in charge with practically no supervision from a physician. This is not mentioned as an ideal arrangement, but it emphasises the importance of intimate knowledge of the symptoms and natural course of the disease. Without this it is difficult to regulate the treatment. The Sisters have acquired this knowledge through years of careful observation of the patients. As a result, in combination with simple clinical laboratory tests, it has been possible for them to carry out the treatment without mishaps and with considerable efficiency.

In British Guiana the results appeared similar to those in Trinidad and Jamaica, the main difference being that there was in the leprosarium a far larger proportion of non-lepromatous cases (40 per cent) unsuitable for sulphone treatment. Partly for this reason the morale of the patients was less high at the time of my visit.

In Barbados, which I visited last, and where I made only a very short stay, sulphone treatment (diasone) had been introduced 5 months previously. Encouraging results had been obtained in the few patients treated for that period. In Grenada and St. Lucia sulphone treatment had not begun.

#### FACTORS IN THE SPREAD OF LEPROSY.

The countries and colonies comprising the Caribbean area show a varying incidence and may conveniently be divided under three categories: those in which leprosy is a major problem, such as Colombia and French Guiana; those in which there is a moderate incidence, such as Cuba, Trinidad, British and Dutch Guiana; and those in which the spread of the disease is slight, most cases arising through direct or indirect contact with the more affected areas.

So far, control in the small islands of the third category has aimed at isolating known cases in asylums which cost the government a large amount *per capita*, and yet are too small to justify expert medical, nursing and general care. These places have in consequence been avoided by patients, who have remained in concealment, often spreading the disease to their families and neighbours for years before being found and interned.

#### NEW PHASE IN LEPROSY CONTROL.

There is now a prospect that the more effective treatment of leprosy with sulphones may justify a radical change of policy, at least in places where leprosy is of low endemicity.

(1) The policy would aim at the abolition of leprosy asylums as soon as possible and, instead, would encourage patients to come forward early for treatment before they have become a danger to their associates. In other words, the increased attractiveness of treatment would take the place of compulsion. Uninformed members of the public might raise objections to open cases being allowed to live at home, not realising that at present there is often a gap of two or three years between becoming infectious and being isolated. The new system would aim at closing, or at least diminishing, this gap by attracting the patient to treatment at the earliest stage.

(2) To carry out this policy effectively it would be necessary to send two of the medical staff in each colony to undergo a thorough period of study in a suitable centre for at least three months, so as to become familiar with the diagnosis, classification and treatment of leprosy. These doctors would then be available

for consultation, and would be responsible for seeing that both prophylaxis and treatment were effectively carried out.

(3) All persons arriving from endemic countries would be kept under supervision, as would also contacts with known indigenous open cases. Periodic examinations would be made and patients, relatives and others taught the danger of infection.

This method, when once under way, would, it is hoped, be both more effective and less expensive than the present method. Open cases, who were found willing and able to co-operate in isolating themselves at home, would be given domiciliary treatment, if necessary free of charge. Otherwise they would be lodged in an annexe to an infectious diseases or general hospital.

The above scheme is proposed only for countries where the incidence is slight and the majority of cases are immigrants, or have acquired the disease abroad. Where the incidence is higher, as in Jamaica, British Guiana and Trinidad, it would be a mistake at the present stage to abolish institutions for isolation.

At the same time these institutions should be made more attractive. Those without experience are apt to think that attractiveness depends entirely upon food, accommodation and amusements. But still more important is the employment of the patients in useful work carefully adapted to their capacity, talent and interest. In Jamaica and British Guiana I found in the leprosy institutions large proportions of patients in whom the disease was no longer active, and who had no need for isolation. A few of these could not be discharged because of disabilities. The majority however were able-bodied, and were to a large extent taking advantage of their former disease to exploit the resources and comfort of the institutions. At the same time they formed a discontented and unruly element which constantly interfered with the good conduct of the patients. In both places the policy of retaining these patients was imposed contrary to the advice of those in charge. In Trinidad, on the other hand, this element had been discharged, making room for those requiring isolation, and the general morale of the institution was better on that account.