REPORTS

Dr. A. McKelvie writes from the Gold Coast: " I am now sending you statistics of people under treatment for leprosy at the end of 1955. From these, you will see that the work grows. The biggest increase in the number of people under treatment has taken place in the Northern Territories where the number of patients has increased from 6,909 to 12,986 within the year. This has been due to the efforts of Mr. D. G. Turner and Mr. R. Boteler, Leprosy Control Officers who were recruited for the Gold Coast by BELRA

" There are now treatment centres 10-15 miles apart along

all the main and most of the secondary roads of the Gold Coast and we are continuing to open centres along dry season roads. These last will be served by junior staff travelling on bicycles and will be supervised by senior staff when roads are passable. If Landrovers are forthcoming from the United Nations Children's Fund, this will make our work more effective.

" The results of twice weekly DDS therapy continues to be satisfactory. On a visit last month to a group of clinics in the Northern Territories run by a missionary society, I discharged 373 out of the 1,436 persons examined, about 26%. The discharge rate for persons who had received treatment for 18 months or more and suffered from the non-lepromatous types of the disease must be about 90%. In the part of the country I am referring to, one cannot yet speak of leprosy control being established because so many immigrants come over the border from French Territory, being attracted partly by the availability of free treatment partly by the better economic conditions which prevail in the Gold Coast. In addition, a number of nomads cause even greater confusion to the would-be statistician.

" The unsatisfactory feature of leprosy work here is the lack of doctors. Until a few months ago, I was the only doctor engaged in leprosy work in the 91,800 square miles of the Gold Coast. Now there is a second man available for the time being. Consequently, more travelling is being done and the thousands of people who are more than ready for discharge will soon be examined and receive their certificates."

LEPROSY TREATMENT CENTRES IN THE GOLD COAST

Region	Clinics Open	Lepromatous Patients Total	Non-Lepromatous Patients Total	Grand Total
Colony East	48	507	3133	3640
Colony West	59	434	1994	2428
Ashanti	47	413	4194	4607
Trans-Volta Togoland ...	38	214	905	1146
Eastern Northern Territories	82	884	7859	8743
Western Northern Territories	41	539	4704	5243
Unclassified	5			168
TOTAL	320	3018	22789	25975

Kuching Leprosy Settlement, Sarawak

In the Annual Report of the Kuching Leprosy Settlement, the number of patients at the beginning of the year is given as 449.

Of these 113 were discharged on " symptom-free parole leave," and 69 more patients were admitted. Of the 398 at the end of the year, 156 were Sea-Dyaks, and 146 Chinese. Mr. Hamish Macgregor, the Superintendent, worked for many years in the Leprosarium at Itu, Nigeria. The following abstracts from the Report are of particular interest:—

" Perhaps the most interesting point in regard to the admissions is that a number of patients came along for treatment of their own accord, and without waiting to be sent. In addition to this a number of others were brought in by relatives or friends from the settlement who were home on parole leave, and either saw or heard of them and persuaded them to come for treatment.

" The number of discharges, 113, represented 25% of our population, and is the highest in the history of the settlement; a further proof of the efficacy of the sulphone drugs. This figure compares with 59 in 1953 and 34 in 1952."

This year the patients sent a present to Sir Winston Churchill of a beautifully beaded forest palm hat and a hunting knife.

Annual Report of the Medical Department, Tanganyika for 1955.

There was no indication that there was any alteration in the incidence of the infection during 1955. Admission to leprosaria followed the pattern of previous years, and although more patients came under out-patient treatment, this was the result of expansion of facilities and greater attention being paid to the disease, rather than to any increase in incidence.

In several districts the development of organised out-patient treatment with sulphones made good progress. This was especially so in the Southern Province with the development of the treatment centres in Newala, Masasi and Mtwara Districts based on the Mkunya Leprosarium. In Morogoro also good progress was made and substantially more patients were brought under treatment.

Out-patient treatment is readily organised in areas where communications are good and populations are concentrated. Where the population is scattered as in such districts as Singida and Kilosa, it is not such a straightforward matter, and in these districts progress has been less marked.

Report on Public Health, S. Rhodesia, 1953

Leprosy

Information regarding the patients under treatment in the two leprosaria is given in Table A of the Appendix. An the end of 1953, for the first time for very many years, there were no non-

African patients under treatment in these institutions. The admission and discharge figures of African patients for the past five years are of interest:

	1949	1950	1951	1952	1953
Admissions	314	330	367	330	295
Readmissions	101	104	118	119	102
Discharged cured or arrested ...	208	253	207	384	448
Deserted	52	71	66	38	94
Died	54	56	29	33	28

Admissions have not varied greatly but there has been a big improvement in cases discharged cured and arrested. The overcrowding has therefore been greatly eased. The success of the sulphones in treatment is already providing much encouragement to indigenous patients to come forward voluntarily for treatment, since cured and arrested cases return to their homes and, from the knowledge they spread, other sufferers come in for treatment. In any case a high proportion of the cases come from neighbouring territories; at Ngomahuru, of 132 male admissions only 48 were Southern Rhodesians. In fact a number of alien cases are known to have come into the Colony ostensibly to seek work, but in fact to seek admission for treatment of leprosy.

All patients are now on DADPS therapy and making good progress. The present routine is one tablet (100 mgm.) daily six days a week for six weeks, and thereafter a maximum dose of two tablets daily, six days a week. Reactions are infrequent and of a mild nature. Ferrous sulphate is also given as a routine.

Report on Leprosy in the Sudan

The results of a survey done by a lay worker of BELRA in Central District of Equatoria during 1951/52 and 1952/53 became available. Over 27,000 persons were examined. The incidence of leprosy was 44 per 1,000. This may be compared with the figure of 52 per 1,000 reported by Abbott amongst the Azande and that of 20 per 1,000 resulting from a less extensive BELRA survey in the Moro district. The Medical Officer, Li Yubu, considered that the incidence in the district was as high as 65 per 1,000.

The total number of lepers in settlements in Equatoria was 1,329. This figure was less than 12 per cent of the total known lepers in the province, while the surveys indicated that the actual number of cases in the province is certainly greater than the total known cases.

A majority of cases of leprosy in Equatoria is of neural type. In the Central District survey only 10.2 per cent of cases were classified lepromatous.

BCG VACCINATION

[In view of the possible rôle of BCG in increasing resistance to leprosy, the conclusions reached in a recent paper appearing in the British Medical Journal, Nov. 12th, 1955, on *Protection of Infants against Tuberculosis*, may be of interest to readers.]

That infants are at risk and that this cannot be prevented. That vaccination at birth is safe, practicable, and effective, though it does not obviate the need for segregation and for general hygiene and education in hygiene. That it would appear that vaccination is effective in protecting throughout the danger period of infancy, though we do not know whether revaccination may not be necessary at 10-12 years; this may well depend on any exposures in the intervening years. That, of all the vaccines we have used, quickest conversion is afforded by the standard Danish BCG. That a half-strength vaccine—that is, 0.375 mg. per ml.—is preferable for this work in infants, as it allows for more accurate dosage. That the complications are mainly directly proportional to the antigenic potency of the vaccine and to the dose given. That until the tuberculous antigen is isolated, vaccination with live attenuated bacilli offers a sound means of protection, and, because of the urgent need of this protection from the earliest moment, vaccination may most profitably be undertaken in the newborn period despite the slightly increased risk of glandular complication at this early age, provided the vaccine is given in accurate dosage, by an experienced person.

That when potent freeze-dried vaccine is available generally the problem of "shortevity" and temperature control will no longer cause difficulty in distribution. A freeze-dried vaccine, free from clumping when dissolved, and containing a known number of evenly distributed and living bacilli, allowing of accurate controlled dosage, will be a great step forward.

That in view of the need for careful follow-up and the difficulty of getting sufficient trained personnel it would not be practicable to carry out mass vaccination in the newborn at present even if that were desirable. Nevertheless, where facilities exist—that is, in maternity hospitals and where there is experienced paediatric supervision—we believe that vaccination in the newborn period offers a very real contribution to the protection of infants against tuberculosis, and we consider that it might with advantage become an accepted part of the "care of the newborn" in maternity hospitals. But, apart from such hospitals, we think that it should at present be reserved for infants who are known to come from, or be going to, tuberculosis households, and in these it

should be a routine procedure as soon after birth as possible—that is, during the first week of life. Many such infants are, of course, born at home or in district maternity homes, and not every district has a paediatrician, but there are maternity and child welfare doctors in all areas, and one or more of these from each area could be trained to undertake this special work without its adding greatly to his or her existing clinical commitments, and so all infants at known risk could in fact be satisfactorily vaccinated.

I would conclude with the warning that with the changing pattern of tuberculosis and the rapidity of introduction of new antituberculosis chemotherapeutics our future programme may well differ significantly from that which I have outlined.