

The Editor,
Leprosy Review.

Dear Sir,

Dr. J. T. Worsfold's results for Rhodesia resemble those of the extensive surveys in Uganda which I have published at various times, namely a child rate of between 18% and 19% and an equal sex distribution. In some respects, however, his interpretations differ from my own.

The extremely low conjugal rate, which is the usual experience, suggests that something other than prolonged intimate contact is necessary for infection, and the fact that so many cases show their first clinical signs in later life may have a significance other than that of a prolonged latent period, although the lengthening of this period is probably a feature of a decline in an endemic. In East Africa there is a fall in the incidence between the ages of 15 and 20, which may also be traced in the figures published from other countries. It suggests that in this five year period the losses by death are not replaced by new cases and that there is an intrafamilial risk in childhood followed by an extrafamilial risk in adolescent and adult life.

The relative proportions at risk in each period will naturally vary with the opportunities for contact that society provides. This has an important implication for schemes of control, especially those which concentrate primarily on children, for apparently susceptibility does not necessarily decline with age.

The sex distribution and the lepromatous and non-lepromatous rates often appear to be related. Where the lepromatous rate is high males are principally affected, with a ratio as high as 2 : 1; where the tuberculoid rate is greater, the sex ratio approaches equality. This latter is true in Uganda and may be inferred from survey reports elsewhere. The fact that some institutional figures differ from Dr. Worsfold's findings in the field should not lead him to doubt his observations. In Uganda where the ratio is 1 : 1, the proportion in settlements often approximates 2 : 1. This relationship is seen in figures from general hospitals for ordinary diseases and indicates the customs of the people rather than the incidence of the disease. In under-developed countries there are many reasons why women attend hospitals less often, just as there are reasons why there are fewer girls at school than boys. In fact I judge the efficiency of the Uganda scheme of control by comparing the sex and child ratios in settlements, treatment villages and clinics with those I have found in surveys of whole population groups in the field.

There are many very interesting conclusions to be drawn from such epidemiological studies of leprosy which compensate to some extent for the impossibility so far of obtaining answers by a direct approach through the culture of the organism and the use of an experimental animal. I hope Dr. Worsfold will accept my congratulations on his work with the comments I have briefly offered.

Yours faithfully,

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Medical Headquarters, Uganda.