

## REPORTS

*Leprosy in British Guiana; Annual Report of the Director of Medical Service for 1958, pp. 15-16.*

The registered patients number 1,288, or 2.7 per thousand population. During 1958 new cases were 76, of whom 48 were children. The tuberculoid-lepromatous ratio over the past six years has changed from 4½:1 to 2:1. Leprosy surveys among school children have been carried on since 1954, and 311 cases were found among 307,394 children examined. The Medical Department is anxious to improve its leprosy campaign and has sent a medical officer for training and experience abroad. On his return, he is expected to do a country-wide survey, the three out-patient centres existing will be improved, and improved laboratory facilities for leprosy will be provided. A rehabilitation scheme has been approved. *Central Leprosy Hospital, Makogai, Fiji; Annual Report of the Medical Department for 1958, Suva, Fiji, pp. 25-29.*

The leprosy work on the island of Makogai since 1911 has the leprosy hospital and patients' villages in the north, with cultivated land, and the staff houses and a small farm in the south of the island.

The patients in Makogai at the end of 1958 were 350, comprising 120 Fijians, 172 Indians, 18 Europeans and part-Europeans, 140 Chinese and others. They all get on harmoniously and live in villages outside the central hospital, each race having a village. Within the hospital live all the female patients and those males who are too sick, too young, or too old to look after themselves in the villages. Married patients are allowed to live together and children are removed at birth and brought up by the Sisters until old enough to be sent to relatives outside. No marriages are permitted between patients and no healthy relatives of patients are allowed to live on the island. Makogai from 1911 to 1958 has treated 3,771 patients, and secured 1,658 cases of arrest of the disease. During 1958 there were 38 admission, 121 discharges, and 11 deaths. Lepromatous cases tend to be twice the number of tuberculoid cases. The standard treatment has been DDS by mouth or injection. A trial was made of DDS in chaulmoogra oil by injection twice weekly: no great advantage was seen. Other drugs were tried on 60 patients in balanced groups, viz streptomycin, INH, PAS, and a control group on oral DDS. The trial was continued for a year; they all progressed in much the same degree. Active tuberculosis occurs and is treated on orthodox lines. There are Radiography and Physiotherapy Departments. Surgery was carried out in 102 cases, and Dentistry is available, and occupational therapy, and the laboratory is very active. Smears alone numbered 5,594.

The staff consists of the Medical Superintendent (Dr. D. Beckett), the Superior and 17 Missionary Sisters of the Society of Mary, and an Executive Officer and 13 other staff, and 41 labourers.

*Belgian Leprosy Centre, Polambakkam, Madras State, India; Report at December, 1958, on the activities of the Leprosy Control Campaign since July, 1955.*

Dr. F. Hemeryckx has provided an extraordinarily interesting and full report of 40 pages on this leprosy campaign, which has over 15,000 patients under treatment. The "Fondation Belge pour la Lutte contre la Lèpre" has provided this effort to India with the intention of handing over the whole at the expiry of five years of work. It is basically a rural scheme which emphasises early treatment, and the medical teams and mobile units contain a large number of ancillary workers, and there is a constant and vigorous case-finding process. The scheme very wisely has retained a centre at Polambakkam for hospitalisation and treatment of acute and other complications, laboratory work, and training of staff, and for surgery and physiotherapy. There are four doctors, two nurses, one social worker, one laboratory technician, 20 rural leprosy workers stationed in clinic villages, and other workers who bring the total staff to 54. The expenses are under Rupees 100,000 (£7,500 sterling) per annum. The average cost per annum per patient is approximately Rs. 300 (£22 10s.).

In the clinics no patient has to walk more than three miles. Clinics are held at 7 a.m. to avoid the heat of the day. The patients were found eager for treatment and the scheme expanded rapidly. In the surveys the total population according to the 1951 census is 380,000, and of these 309,789 were examined, and the general incidence of leprosy is 38 per thousand. The lepromatous rate is 14.55%. The sex ratio of males to females is 66.2/33.8. Deformities are 10.8% of all patients for the hands, foot 2.5%, nasal deformity 1.2%, gynecomastia 1.9%. The result of all this is that there are 3,727 cases requiring surgery. The overall attendance of patients is 45%, but the lepromatous have a higher rate of 72%. It was noted that patients with deformities lose heart as they see little effect on their deformities, but return when physiotherapy and surgery are made available. In all cases when symptoms disappear there is a tendency to fall off in attendance. A study is being made of such cases, and an effort is being made to keep them under observation. There are also economic and social causes for irregularity of attendance. The solution seems to lie in an increase of staff, both medical and social workers. The basic treatment is oral DDS on a routine dosage of 600 mgm. weekly, induced slowly. About 38% have reactions, with a peak in the cold season of January to March. Hospitalisation is needed but some may be treated as out-patients if there is strict medical control. The hospital ward was opened in March 1957, and since then there have been 655 admissions. It became clear that a hospital is needed in every leprosy scheme. The results of treatment are assessed as 67.4% likely to be cured by DDS;

9.3% need more treatment. Those with no improvement, 5.7%, and those worse 3.5%. Physiotherapy and surgery are still needed for 23.3%. BCG and prophylactic DDS have not been used so far, nor special protection of children. Integration of the leprosy scheme into the general health and medical services has not made much headway. Physical rehabilitation has been much advanced by the work of Dr. Paul Brand and colleagues, and training of staff goes on steadily.

*East African Leprosy Research Centre (John Lowe Memorial); Annual Report for 1st July, 1958–30th June, 1959.*

This Centre is situated at Alupe, Kenya. Its postal address is a few miles across the border in Uganda (P.O. Box 4004, Busia, Uganda). This will cause confusion unless it is remembered that the postal address indicates only the proximity to Uganda and not its true geographical location.

The Director, Dr. J. M. B. Garrod, is assisted by a biochemist, Mr. G. A. Ellard, M.Sc., and a laboratory technologist, Mr. R. Rhodes-Jones. Mrs. Rhodes-Jones acts as photographer. The Director is now in medical charge of the adjacent Kenya Government Leprosarium and undertakes the medical supervision of six leprosy clinics in Uganda and four in Kenya. Mains electricity is now in use in the Centre, financed by a generous gift of £4,000 from BELRA.

Using the ferric chloride method developed previously at the Centre, Mr. Ellard has carried on studies of the absorption and excretion of SU 1906 (DPT) and its metabolite. Approximately one-tenth of the oral dose of SU 1906 is absorbed and metabolized. Attempts to isolate the pure metabolite have not yet been fully successful. Preliminary work on radio-isotope uptake by bacilli has been started by Dr. R. Naylor of Makerere College. Trials have started on Etisul (diethyl dithiolisophthalate) by inunction for the treatment of leprosy. So far, progress has been found to be four times as fast as with standard treatment. Drug resistance occurs when Etisul is used alone, but is held off by using other drugs with it. Clinical, bacteriological, and histological progress run closely parallel. Control cases have been studied for these clinical trials.