

EDITORIAL

1. Classification of Deformity in Leprosy

The Vellore 1960 Conference on Rehabilitation endorsed the Scheme of Classification for disability resulting from leprosy (WHO Technical Report Series 1960, 189 22–23 and WHO Technical Report Series 221 1961, 33). The scheme is simple and practical and we reproduce it to help in its becoming more widely known and used. There are four sections, A. HANDS, B. FEET, C. FACE, and D. MISCELLANEOUS, containing gynaecomastia (Type 1) and laryngeal involvement (Type 2). The details of the other sections are:

A. HANDS. *Grade 1*, anaesthesia to pain; *Grade 2*, mobile claw hand, with a useful thumb; *Grade 3*, intrinsic paralysis involving fingers and thumb, or fingers only, but with contracture; *Grade 4*, partial absorption of the fingers but with useful length remaining; *Grade 5*, gross absorption with stumps only left.

B. FEET. *Grade 1*, anaesthesia; *Grade 2*, trophic ulceration, past or present; *Grade 3*, paralysis (drop foot or claw toes); *Grade 4*, partial absorption of the foot (loss of up to one third of the plantar surface area); *Grade 5*, gross absorption (more than one third of the foot lost).

C. FACE. *Type 1*, a permanent mark or stigma of leprosy not amounting to ugliness (e.g. loss of eyebrows, deformity of the ear); *Type 2*, collapse of the nose; *Type 3*, paralysis of the eyelids, including lagophthalmos or paralysis of the facial nerve; *Type 4*, loss of vision in one eye or dimness of vision in both eyes (can count fingers); *Type 5*, blindness.

For record purposes, it is suggested that conditions under A, B, and D1 are noted as unilateral or bilateral.

2. Laboratory Services in Mass Campaigns

Many workers in widespread leprosy control schemes or in mass therapy campaigns in countries where leprosy is highly endemic have a disquiet of mind at the way laboratory services lag behind. For example 10,000 or even 200,000 patients may be sought to be brought under treatment when there is barely laboratory aid available to do the necessary bacteriological smears before, during and after treatment. Still less there may be any hope of histology, immunology, and frequent smears such as are needed whenever one of the speedier drugs becomes available (such as call for a smear every week rather than every six months!) This defect of laboratory service is due to lack of the staff, but we shall never get the staff and the facilities unless we have a clear idea that we need them and never cease to ask for them. In a static and mobile mass campaign why should we not

have a mobile laboratory service in addition to adequate static laboratory services? Are we to do field research without any aid on the field from laboratory services? There has already been one great recent revolution in leprosy relief, namely the realisation of the preventability and curability of leprosy deformities. We think another great revolution should follow it, namely the availability of adequate laboratory services in leprosy campaigns, and the undertaking of more field research based on adequate laboratories, even mobile laboratories.

3. Health and Tuberculosis Conference

The Secretary of the Chest and Heart Association, London, informs us that a Health and Tuberculosis Conference will be held at University College, Ibadan, Nigeria, 26th–31st March, 1962. From the United Kingdom delegates may travel by charter plane leaving London on 24th March and arriving back on 2nd April, 1962. Those wishing to attend this Conference which will include a section on Tuberculosis and Leprosy should communicate with the Secretary, The Chest and Heart Association, Tavistock House North, Tavistock Square, London, W.C.1.