Editorial

I.—DEATH OF A GREAT LEPROLOGIST

DR. CHARLES M. ROSS died on 24th June, 1964. The death of this good, great man has deeply affec

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C. M. ROSS, O.B.E., M.B., B.CH., B.A.O., S.T.M., C.P.H.

The unexpected death of DR. C. M. ROSS at Nairobi on 24th June at the age of 61 was a grevious loss to a wide circle of friends and to the cause of leprosy control.

CHARLES MCCONAGHY ROSS was born in 1903, a member of a family well known in medical circles in Northern Ireland. He graduated M.B., B.CH., B.A.P. at Belfast in 1926, and after working for two years in the Dublin Medical Mission he offered his services to the Qua Iboe Mission, being appointed medical officer at the Etinan Hospital in south-east Nigeria in 1928. In addition to an extensive surgical practice his responsibilities there also involved the care of leprosy patients at the neighbouring leprosarium of Ekpene Obom, and the great need of these sufferers led him to the decision to specialize in leprosy.

In 1940 he offered his services to BELRA and became my colleague at Uzuakoli Leprosy Settlement. At that time rural leprosy control had begun to develop in Eastern Nigeria, and the possibility of its widespread expansion was opening up. In this pioneering atmosphere his great gifts found rich fulfilment. His boundless energy and common sense, his professional skill, his transparent sincerity, and his love of the countryside and its people not only endeared him to innumerable patients but inspired confidence and respect among chiefs and local authorities.

Quite apart from sufferers from leprosy, his professional services were much sought after by members of the general public, both African and European, and in the midst of an exceptionally busy life his courtesy and skill were always at their disposal. In 1947 he was appointed medical superintendent of the Rivers Area of the Nigeria Leprosy Service. Much of the planning, both of a central leprosarium and of a widespread anti-leprosy organization in the Niger Delta, devolved on him, and development was so rapid that ten years later leprosy had become of secondary importance in the area. In 1953 he had already accepted the post of specialist leprologist in the Northern Region Leprosy Service. Here he faced a formidable task. A few small stereotyped Government leprosaria and a number of Mission leprosaria were only touching the fringe of a vast problem, aggravated by religious sanctions and the wide expanse and large population of the territory. Fact-finding surveys led to unconventional methods of leprosy control, in which he both sought and

won the co-operation of Government and Mission doctors, nursing sisters, and lay-workers on an unprecedented scale, so much so that when he retired in 1961 200,000 leprosy patients were receiving treatment and a nation-wide campaign was in progress.

His pioneering spirit could not be satisfied with retirement, and in 1963 he became the director of leprosy research in the East African Common Services Organization. His contributions to leprosy journals were numerous. Over the years his unique experience of leprosy survey work enabled him to undertake, at the request of the Governments concerned, surveys in Sierra Leone and Gambia, on which subsequent leprosy control programmes were formulated.

Workers in tropical public health with the indomitable spirit of Charles Ross can ill be spared, but there are many who, while mourning his loss, remember with admiration and gratitude those personal qualities which expressed so nobly the Christian faith which meant so much to him.

To his wife, his constant and equally devoted companion over many years, we offer our deepest sympathy.

T. F. DAVEY

DR. J. ROSS INNES *writes:*

DR. ROSS's leprosy work was particularly notable for reliable leprosy surveys in Gambia, Sierra Leone, and Bornu in Northern Nigeria. In December 1952 he went to Kaduna as leprologist to Northern Nigeria. There his work was stupendous. He succeeded in training paramedical workers and set up a dispensary and leprosarium control scheme for over 200,000 patients. I personally visited Northern Nigeria and saw his work at first hand, and the energy and hard work and practical effectiveness of the Northern Nigeria campaign under Dr. Ross were outstanding. He also went to Ceylon under WHO as adviser in the leprosy programme there.

The scientific contributions of Dr. Charles Ross were numerous and valuable in trials of certain new drugs. Above all he had a flair for reliable assessment of leprosy incidence. These surveys were done with a small number of personnel, including his wife, who brought her nursing knowledge and practical knowledge of leprosy to the task. The result was that if one really wanted to know the leprosy incidence of a country or area Dr. Charles Ross having surveyed it gave the truth.

His whole life was directed, therefore, to leprosy investigation and relief, and countless patients in Africa will now be grateful for his hard work and efficiency. As a colleague Dr. Charles Ross was known to all leprologists for his integrity, grace, and lovableness.

DR. T. F. DAVEY who knew DR. CHARLES ROSS very well in Nigeria has kindly written the following additional intimate reminiscences.

DR. C. M. ROSS – *A colleague remembers*

I first met Dr. and Mrs. Ross at Uzuakoli railway station late one night

in February 1940, when in the service of BELRA they came to join our small staff. In those days when leprosy work seemed to attract more than its share of unusual people one met newcomers with some trepidation, but here were colleagues after our own heart, bringing with them several years of experience in medical work at Etinan, E. Nigeria. They arrived when village leprosy control work had begun to expand, following a visit by DR. E. MUIR in 1939. At the time of their arrival opposition to leprosy work was still considerable in many areas, and nothing would wear it down but the personal visits of a leprologist with understanding and great friendliness. Charles Ross was ideally suited for this work. He was first and foremost a pioneer, a quality he shared with his wife, and for many years they were never more happy than when on tour in some deeply rural area, undertaking surveys, establishing treatment clinics, and ministering to the sick.

During the years of our colleagueship we used to alternate our medical duties weekly, so that one of us would be on tour, the other at the Settlement. Touring was no picnic, particularly during the difficult war years, but regularly on alternate Mondays Dr. and Mrs. Ross would set off in an overloaded kit-car, with African nurse or laboratory technician, houseboy, their combined camping equipment, medicines and dressings, and sometimes with a bicycle tied on the side of the car. Travelling over rough unmade roads, sometimes even constructed by the people for our use, they would set up house in a remote unfurnished rest-house, returning at the end of the week with some new advance made, new patients found and treated, the promise of a new clinic, or a site offered for a segregation village. They usually reached their objective, for Charles Ross was no mean motor mechanic, and when they returned there would likely be a very sick patient squeezed into the car somewhere, while during succeeding days a little procession of patients would arrive with their relatives, to receive the help it had proved impossible to give at a lonely outstation. This was work he loved, and amid the heavy administrative responsibilities which later years brought to him it never lost its place in his heart.

Charles Ross's skill as a surgeon was quickly discovered by the local people, and his fame spread far and wide. With Mrs. Ross a highly competent midwife, they made an unusual combination. Obstetric emergencies were brought from miles around, often in extremis, but the life of every mother saved was regarded by the people as a miracle, and the goodwill and personal affection so engendered greatly encouraged, not only the spread of leprosy work, but a new outlook in the area on modern medicine generally. Apart from the Settlement there was for many years only one other medical centre with a resident doctor to meet the needs of an entire county, and it is therefore not surprising that when at 'home', Dr. Ross usually found his hands full, succouring not only leprosy patients, but members of the general public with grave surgical emergencies. This work involved many a night call.

It was characteristic of him that his patients felt that all his interest

and care were being given to them personally. This was the quality of his friendliness, and though it made heavy demands upon him, his physical energy and resilience seemed always sufficient. Children loved him, and our Nigerian staff were deeply attached to him. They appreciated his sense of humour, his sympathetic understanding in their personal troubles, and his utter reliability.

He was a very sociable person, and loved a party. His impersonations of mutual friends, amusing but never barbed, are not easily forgotten. A loyal Ulsterman, he always celebrated Orange Day with a band and a miniature procession, to the mystification of the patients, who out of their regard for him joined in for the fun of it. Endowed with a robust physique, it is not surprising that he enjoyed sport. He saved many a goal while playing in the staff soccer team.

More than all, one treasures the memory of him as an intimate personal friend, with whom hopes and fears could be shared, and common ideals find expression. His enjoyment of life was infectious, and many are the richer for having known him.

T. F. DAVEY

II.—This issue of *Leprosy Review* is by way of being a Symposium on Plantar Ulcer. Several workers who are specially concerned with Plantar Ulcer have responded to our request to contribute to this subject and their papers are printed in this issue. It was necessary to set a limit of time for such papers and naturally those papers are included which arrived in time for printing. By way of preliminary remarks, E. W. PRICE has kindly sent useful introductory remarks on Plantar Ulcer which follow here.

Ulcer on the sole of the foot is one of the commonest disablements of leprosy; it also causes more difficulty to leprosy workers than other lesions because of its persistence and of the number of patients involved. Half or more of the beds available in a leprosy hospital are often occupied in this way and the persistence of the ulcer makes it difficult to send them home even when the leprosy itself is arrested.

It is the purpose of this symposium to clarify the causes of ulcer on the sole, and to give clear indications for treatment. The condition is amenable to modern therapy.

Ulcers on the sole of the foot can be simply classified as follows:

(i) Ulcers which are infected wounds – caused by such things as thorns, nails in footwear, simple infection.
(ii) Plantar ulcers – a specific lesion of the mobile neuropathic foot.
(iii) Ulcers which occur due to friction and pressure on the prominent part of a deformed and rigid foot.

The cause, prognosis and treatment of each of these types is different, and failure is due to the application of wrong treatment.

The specific lesion of the walking and mobile neuropathic foot is described as 'plantar ulcer'; other terms are 'neuropathic ulcer', 'trophic ulcer', 'perforating ulcer'. The term is used to underline the relation to

walking and it can only occur on the sole. No term is completely satisfactory, but 'plantar ulcer' as a term is similar to that of 'duodenal ulcer' where it is generally agreed that it refers to a specific lesion and does not include such ulceration as caused by a fish-bone or by a gall-stone.

In the present state of our knowledge, *all plantar ulcers should become healed and remain healed with modern treatment.* They represent a problem in nerve damage and not in leprosy *per se;* they may persist long after the leprosy is arrested.

It will be seen, from the following pages, that modern treatment includes the provision of *special footwear.* This can be provided at a cost of US $1.00 per pair in most developing countries. It will always be found that some patients in a rural community are familiar with working with wood and can readily copy a model; the first technician used by the writer was the local ju-ju carver. To treat plantar ulcer without having footwear available is deficient medical care.

An *X-ray machine,* to diagnose the extent of bone infection, is useful, and is indispensable if the concomitant lesion of neuropathic joint (a frequent association) is to be recognized. But large numbers of ulcers will heal and remain healed without this facility. The same is true of *surgical facilities;* it is sometimes an advantage not to have a knife available to incise into a neuropathic foot!

Plantar ulcer is always preceded by a pre-ulcerative state which is clinically obvious for ten days before ulceration occurs. It should be considered a criticism of the medical attendant if plantar ulceration occurs in a patient under constant care, since it can always be avoided by *regular weekly inspection* of feet under risk – *i.e.* feet with sensory deficit.

Finally plantar ulcer presents a *problem in psychology and social welfare.* Ulcers often persist because the owner fears that healing will make him suitable for discharge from the security of a leprosarium.

It is surprising how patients soon learn how long they can dispose with footwear daily in order to avoid complete healing of an ulcer.

III.—*Errata* in an important paper by DR. P. ONDOUA, MISS M. TH. PROST, and SISTER M. DE LA TRINITE on Clinical and Immunological Results Obtained with the *Marianum* Antigen after more than Ten Years of Therapeutic Use.

Certain unfortunate *errata* arose in this paper which was published in *Leprosy Review,* July, No. 4, 1964, pages 169–173, and the misunderstanding was on the important matter of what the authors really said. We have asked the authors to send a new correct version which appears in this issue on page 297.