

## Editorial

The number of pages in this and other issues of *Leprosy Review* devoted to reports on various surgical aspects of leprosy is to be taken as an indication of interest rather than as a recommendation of emphasis. The importance of adequate medical treatment following early diagnosis of leprosy remains unchanged, and the theoretical ideal—at present generally unattainable—of prevention of preventable deformity must ever be in the forefront of the thinking of health planners and practical leprologists.

It is only in rare instances, however, that the men, the means and the vision are concurrently available for leprosy programmes that enshrine the ideal. Most readers who have to grapple with the day-to-day problems of diagnosis and management, of organizing and supervising, are facing both a regrettable repetition of the sad story of neurological deficit resulting in neuropathic atrophy and ulceration, and a sizeable backlog of physical handicaps of one sort and another due to untreated leprosy. It is hoped that the publication of good work in research, treatment and prevention may prove helpful and stimulating to the specialist reconstructive surgeon and the “jobbing surgeon”.

The earlier enthusiasms and popularizings that surfaced after the pioneering efforts of Brand had received their due acclaim, have given place to a more sober appraisal of the place of reconstructive surgery in the whole programme of leprosy treatment and control. However attractive and technically challenging the problems posed by deformity in leprosy, and however valuable to the leprosy campaign the “before-and-after” visually convincing results of reconstructive or plastic operations, leprosy is still basically a medical and an epidemiological problem (with, of course, its attendant social repercussions), and the continued occurrence of “surgical” complications and sequelae is a measure of our medical ignorance or administrative short-sightedness. We can see the value to the individual sufferer, and to the community, of some kind of surgically-orientated rehabilitation scheme, incorporated into a leprosy control programme, but we can also see the importance of so treating leprosy as to obviate the need for surgical and social rehabilitation. The amplitude of the swinging pendulum is much less, and also much less jerky, than it was.

Here and there, the backlog of deformity has been tackled with commendable competence and determination. In Carville, Louisiana, a succession of surgeons, drawing on consultative skills at nearby Tulane, have been at the disposal of the handicapped. Hay Ling Chau is coming to the end of its rôle as a reconstructive agency as the Hong Kong Government takes over the irrecuperably deformed and the manageable accession of patients with new infections. The excellent work of Carayon and his colleagues at Dakar, Bamako, Marseilles and elsewhere is becoming more widely known, and elsewhere in this issue (p. 122) we refer to the prize-winning report by Van Droogenbroeck of his work in Korea. Similarly, the

government-sponsored and mission-aided surgical rehabilitation programme in Papua and New Guinea, which owes much to the inspiration of Clezy, has made commendable inroads on the accumulated deformities due to leprosy.

These situations, however, are rare and atypical. The more usual problem is the volume, often unsuspected, of deformity due to leprosy and the dearth of means available for tackling it. The average leprosy programme planner has not yet grasped what can be done, within the imposed limitations of time and staff and money, to adopt and adapt the basic principles of reconstructive surgery and preventive rehabilitation.

There is evident, too, a certain disillusionment, a kind of rebound phenomenon, in the application of surgical techniques to the deformities of leprosy. The over-enthusiasm of a few has resulted in a misplaced emphasis that views leprosy as a "surgical disease". Not only has attention been diverted from the gnawing problem of new infections, but the improvements resulting from surgical interventions have often been illusory or short-lived: the continuing incubus and tragedy of unrelieved sensory deficit has not always been appreciated by patient and surgeon alike. A good anatomical result does not necessarily mean perfect functional restoration. Careful selection of cases, consideration of the patient's real needs and the enlistment of his co-operation at all stages, adequate physiotherapy and good nursing both before and after operation, and the timely provision of prostheses these very obvious desiderata have not always been respected, despite the fact that the workers at Karigiri, Addis Ababa, Hong Kong and elsewhere have for years been emphasizing their importance.

What, then, is the outlook for today? Where lies the middle way between an extensively equipped Surgical Rehabilitation Unit dealing with a mere handful of patients whose physical deformities are due to neglected leprosy, and a leprosy control programme integrated into the general health services whose resources do not appear to permit of even the sketchiest attempts at reconstructive surgery? Wherever possible some kind of expertise should be available at every central hospital of every leprosy scheme. It may be that one of the doctors in charge (or the only doctor) will attempt to become proficient at the more ordinary surgical tasks—dealing with such conditions as neuropathic foot ulceration, and to perform tibialis transfer for drop-foot deformity, operations on peripheral nerve trunks, tarsorrhaphy for lagophthalmos, etc. With the help of such a manual as Fritschi's *Reconstructive Surgery in Leprosy* [see *Leprosy Review* (1971) 42(4), 290], and a short apprenticeship under an experienced surgeon, the average medical practitioner can become reasonably competent. Such a pattern obtains in L. PRA'S project in Malawi, and would be applicable elsewhere.

For more complicated surgical procedures, such as operations for flail foot, tendon transfer operations for the various degrees of claw hand, temporalis transfer for severe lagophthalmos, and the more demanding techniques of plastic surgery, longer training is necessary, and not all doctors have the requisite flair or potential. This training may be had in such institutions as Karigiri (South India), and ALERT (Addis Ababa), and individual surgeons with special interest and experience have from time to time taken pupils under their wing. On-the-job training has been given by surgeons well versed in the techniques of reconstructive surgery as applied to leprosy, during extended visits paid to different centres; surgical techniques have been demonstrated, and physiotherapeutic and prosthetic services have been inaugurated. Special courses have occasionally been given to groups of young general orthopaedic surgeons hoping to devote time to the surgery of leprosy.

Although many of the problems of reconstructive surgery in leprosy require rather special knowledge and techniques, the bulk of them may be handled satisfactorily in a Rehabilitation Unit dealing with other crippling diseases and conditions, such as congenital deformities, poliomyelitis, tuberculosis, accidents (road, domestic, factory, mine or forest). The "segregation" of leprosy should not be perpetuated or fostered by the provision of facilities tending to take leprosy out of the main stream of surgery and rehabilitation.

Many of the practical problems confronting the surgeon may be seen either as a challenge to his technical and operative skill, or as a stimulus to his enquiring mind. The pathology of nerve damage, the histopathology and immunology of tissue response in nerves and muscles and bones, the patterns of motor, sensory and sudomotor deficit—all pose unsolved problems with intensely practical sequelae. The pathways pioneered by Antia, Brand, and Carayon are now being trodden by Ranney, Warren, and their colleagues. There is plenty of room for others.