supervision of each dose of the drug. I have therefore not felt that the advantages offered by short course chemotherapy in our practice where we have a fairly large number of patients (about 300 a year) were such as to justify its introduction. I also see major problems in the logistics of a wider scale introduction of short course chemotherapy. With the existing drugs in the presently required dosage frequency it seems to me that if the dose interval is anything shorter than once a week, the logistics of large scale supervised chemotherapy must present formidable problems and I would not be convinced that in the third world countries where tuberculosis remains a major problem the skills that are required for this would be available.

I am sorry if my conclusion conflicts with the views of those who are enthusiastic to explore the possibilities of short course chemotherapy in leprosy. My initial reaction to the possibility of short course chemotherapy in tuberculosis was one of considerable enthusiasm, but the information presently available has, as you see, greatly tempered it.

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MARTIN W. McNICOL

Technicians in Reconstructive Surgery

Sir,
This has reference to the suggestion of Dr N. H. Antia, on the floor of the XI International Leprosy Congress at Mexico City (13–18 November 1978), that “Technicians should be trained to do reconstructive surgery in leprosy because of the paucity of doctors available for this work”.

It was surprising that this suggestion came from India’s finest and most well-known plastic surgeon. We in leprosy seldom make attempts to analyse and evaluate the quality of our work. For a good 30 years we have tried to take several short-cuts, without stopping to think whether some of these short-cuts would contribute to the postponement of leprosy control. Dr Antia has added one more weapon to the following existing ones:

(1) Paramedical workers with an education ranging anything from IV grade to school final, being responsible for the care of the vast majority of leprosy patients. From the number of responsibilities assumed by these workers, we tend to assume and give the impression that leprosy is the most simple and uncomplicated of all diseases.

(2) We have leprosy physiotherapy technicians and leprosy shoe-workers who do not know or understand (many of them never capable of understanding) the anatomy and the complex mechanisms in the normal or leprosy hands and feet, yet they give physiotherapy in a mechanical fashion and produce shoes in a stereotype fashion.

Even the most qualified and experienced physiotherapist or shoe-maker will find his greatest challenges in leprosy but we seem to have simplified the gravity of the situation.
Of course these situations have evolved in leprosy programmes due to several constraints including financial but what is dangerous is the fact that these are accepted as "ideal" or at least "sufficient" by most leprosy workers and all government and funding agencies.

"To reach as many patients as possible and do as much as possible with as little money and personnel (as little qualified) as possible" has been our slogan but Mycobacterium leprae seems not to get affected by our mass-scale quantitative approach.

Perhaps a more vigorous qualitative approach is called for. It's time we did some genuine stock-taking before setting up more of our "low cost, large numbered, impressive statistics" projects. Just as we have now started to pay the price for giving dapsone the monotherapy "crown", I would hazard the guess that we shall pay the price for every one of our short-cuts including the one suggested by Dr Antia if implemented, by taking a much longer time to reach our final destination—the eradication of leprosy.

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Reply from Mr N. H. Antia, FRCS

Sir,
Thank you for referring Dr Lobo's letter to me. My comments are as follows:

I agree that under ideal conditions it would be best to have fully qualified surgeons with special training in reconstructive surgery of leprosy to undertake all leprosy surgery. Unfortunately experience tells us that this is not possible for several reasons. Some of these are as follows:

(1) Most surgeons are not interested in working in leprosy because of fear, social stigma and lack of adequate remuneration.
(2) Those who do undertake such surgery do so only for a short period at the beginning of their career when they have little alternative work and drop it when other avenues are open.
(3) Even in proper surgical departments where leprosy surgery is integrated with other forms of surgery, the constant turnover of surgical and ancillary staff does not permit development of a coordinated team. This applies to all aspects of surgery and certainly to leprosy which seldom receives high priority. The poor overall quality of results bears testimony to this.
(4) The achievements of a few centres which are run by people with dedication can hardly fulfil the vast demand for this type of surgery.
(5) The expertise of surgeons not trained in this aspect of surgery leaves much to be desired.