ILEP: THIRTY-SECOND MEETING OF THE ILEP MEDICAL COMMISSION, MADRID, JUNE 1979

President: Dr K. F. Schaller; *Vice-president:* Dr A. Cap; *Vice-president* and *Rapporteur:* Dr A. C. McDougall

Amongst a long list of important topics raised at this Medical Commission (and later reported to the General Assembly by Dr K. F. Schaller) were the following—

1. An Atlas of Leprosy

Professor M. F. Lechat of the École de Santé Publique, Clos Chapelle aux Champs, 30, Bruxelles, Belgium, presented an atlas giving detailed information on the leprosy situation in 59 countries. In their introduction on behalf of the Damien Foundation (to whom we are indebted for this remarkable achievement), Mrs C. B. Mission and Miss Miriam Cap summarize the data recorded by the atlas under the following headings—

(a) *A prevalence map by region:*

The prevalence shows the ratio of *registered patients* against the population of the region.

The source of data is indicated on each map, as well as the year to which they apply. The information has been given either by the Ministry of Public Health or by a correspondent engaged in leprosy work in the country itself.

Considering the important variations of prevalence in the world, and the desire to get a more precise idea in each country, we have decided to use two different scales (indicated on each map).

(b) *A second map* shows the projects supported by ILEP-members. However this has been omitted when those projects cover the entire country through support to a national program. Some maps are incomplete for lack of information.

(c) *Statistical data:*

(a) the population by region,
(b) number of registered patients,
(c) the prevalence (registered patients/population),
(d) number of patients in the projects supported by ILEP-members. If the entire country is covered through a national program, only the total number of patients is indicated.

(d) For some countries, we have been able to show the number of estimated and treated patients.

This formidable work both complements and expands the information already compiled by WHO and should be of immense value not only to ILEP members, but to all those who have responsibility for allocating resources in leprosy control. A copy may be obtained on application to the Brussels address above.

2. ILEP Sample Survey Teams

Dr. D. L. Leiker of the Royal Tropical Institute, Mauritskade 57, Amsterdam, Netherlands, presented further practical points for the formation of these teams, which are envisaged to consist of a medical officer (as team leader), an administrative assistant and/or laboratory technician, and a statistician. It was thought that 2 rather than 3 areas might be covered per year in selected countries with endemic leprosy; that the base could be in Europe (possibly at ILEP headquarters), or in a regional centre such as ALERT in Africa, and that selection of personnel should be from Members of ILEP to the Medical Commission. A detailed job description would clearly be needed. WHO collaboration was invited, especially in the training of team members; Ujung Padang in Indonesia might be a possible centre for such training. The possibilities of combining such survey work with studies on drug intake (compliance), drug resistance and tuberculin testing were also discussed, but it was thought that these additional matters would have to be reviewed in the light of the work-load encountered during actual surveys.

3. Standard Information, Registration and Reporting System for Leprosy (OMSLEP)

Professor M. F. Lechat presented details of this system which is now fully developed and already distributed to a number of countries for field use. It is available in English, French and Spanish; a Portuguese translation is in preparation, and a full manuscript has already been submitted (June, 1979) for publication in the medical press. This is a collaborative project between WHO and the Department of Epidemiology in the Catholic University of Louvain. This operational research project is confidently expected to assist endemic countries in a better definition—and assessment—of their activities. All who are interested in this system, and in assessing its feasibility in the field, are encouraged to contact Professor Lechat's unit in the University of Louvain.

From the same unit in this University, there is also now available a *Central Register of Resource People,* established after extensive screening of the literature concerning all those involved in leprosy research over the past 6 years (from 1974). This has been completed with the help of the Institute for Scientific Information in Philadelphia, Pennsylvania, and the Damien Foundation. The Register prints out a list of over 1500 scientists, with their scope of research and address. Its key words were—Diamino diphenyl sulfone, leprosy, leper, *Mycobacterium leprae,* Hansen disease, Hansen's disease, lepromatous, *lepraemurium,* DDS and lepromin.

4. Combined Multiple Chemotherapy in Malta

Dr D. L. Leiker (Amsterdam) gave a preliminary account of the results of combined multiple drug therapy used in the treatment of patients of various classification in Malta, followed by stopping drug treatment altogether. Further details of this group of patients, which could clearly have a most profound influence on our approach to drug treatment, are not yet available, but some of Dr Leiker's views may be read, as a personal communication in *Leprosy Scientific Memoranda,* Memo L-1025, June, 1979.

(The next meeting of the Medical Commission is in Brussels, on Thursday, 13 December, 1979.)

WHO. Regional Office for the Western Pacific; Final Report on the First Regional Working Group on Leprosy, Manila, Philippines, 7–12 December, 1978. (The report is dated February, 1979)

This is a 57-page report, paper back, A4 size, of an important Regional Working Group, whose objectives were:—

(a) to review ongoing leprosy control activities, including (i) the magnitude of the problem and (ii) the programme management of leprosy control;

(b) to recommend to the Regional Director strategies for the programme management of leprosy control activities in the country in line with the proposed regional strategy, including manpower training for leprosy control;

(c) to review all chemotherapeutic regimens currently being used to determine the frequency of dapsone-resistant cases being encountered;
(d) to develop a system of monitoring the spread of dapsone-resistant leprosy and to propose effective countermeasures to minimize this resistance.

The whole subject of leprosy, as seen in this geographic area, was considered in detail under 16 headings and the Report ends with 4 pages of Recommendations. It is nowadays becoming increasingly clear that the most complex, and at times the most controversial areas covered by such meetings of experts have to do with the treatment of the bacillary infection, and with adverse reactions. It is therefore of interest to read (page 21) that "All suggested regimes for dapsone resistance recommended by the Workshop on Epidemiology and Control, including Field Therapy, at the XI International Leprosy Congress in Mexico City, November, 1978, are moderately priced or very expensive. Therefore possible "low-cost" regimens which could undergo clinical trials are:
(a) Rifampicin 1500 mg, single dose on the first day of treatment, plus clofazimine 100 mg daily for two months, then 100 mg three times weekly, indefinitely and ethionamide 375 mg daily for two months, then thiacetazone 150 mg daily, indefinitely.
(b) Rifampicin 600 mg daily for two weeks, then 600 mg on the first day of each month, indefinitely, plus ethionamide 375 mg daily for two months, then thiacetazone 150 mg daily indefinitely.
(c) Clofazimine 100 mg daily for two months, then 100 mg three times weekly, indefinitely, plus ethionamide 375 mg daily for two months, then thiacetazone 150 mg daily, indefinitely."

Under *Duration of therapy,* (page 22), the text reads . . .

"More research is needed on the duration of treatment in non-lepromatous leprosy. It is proposed here to give simple recommendations, based on the date of commencement of treatment, or of recommencement in the case of relapse through failure to take treatment, or of change to effective treatment in the case of relapse due to the emergence of dapsone resistance.

Type of leprosy	duration of chemotherapy	Period of intensive follow-up (because of threat of reaction, etc)
TT	3 years	0–3 months
BT	5 years	4 months
BB	10 years	0–6 months
BL	15 years	0–12 months
LL	at least 20 years (life preferred)	0–7 years (subsequently an annual complete check for relapse remains essential, indefinitely)

Indeterminate–treat for three years, and then lepromin-test.
(a) if lepromin positive, stop at three years;
(b) if lepromin negative, continue for another three years (i.e. total of 8 years)"

Under *"Suggested field treatment of regimens for reactions"* (page 25) that dealing with severe ENL includes the following recommendations:

"It is suggested that a short-term course of prednisolone should be first given:

prednisolone 10 mg three times a day for one week,
then prednisolone 10 mg twice daily for one week,
then prednisolone 10 mg daily for one week,
then prednisolone, 5 mg daily for one week.

If the patient's skin lesions immediately relapse, or if ENL iridocyclitis, orchitis, neuritis, arthritis or nephritis is not completely cured in a single course, then alternative drugs should be employed.

Possible courses are:

either thalidomide 200 mg twice daily for three days,
then thalidomide 100 mg mane, 200 mg nocte for four days,
then thalidomide 200 mg nocte for two weeks,
then thalidomide 200 mg nocte for eight weeks.
(Do not give prednisolone with thalidomide.)

Or clofazimine 100 mg three times a day for two months,
then clofazimine 100 mg twice daily for one month,
then clofazimine 100 mg daily indefinitely.
Plus prednisolone 10 mg twice daily for the first two weeks,
then prednisolone 10 mg once daily for the next two weeks,
then prednisolone 5 mg daily for the third two weeks (then stop prednisolone).

Patients should be reviewed around eight weeks by the control scheme leprosy specialist. At his discretion, patients may be discharged home on clofazimine, subject to review every three months. Out patient use of thalidomide, although by and large cheap, simple and very satisfactory, must be under direct control of the specialist, and subject to any regulations imposed by the national health authority. Regular checks are advisable to exclude thalidomide neuropathy."

Under *"Recommendations.'* (page 34) extracts from paragraphs (1) and (2) include the following—

(1) In the countries of the Western Pacific Region leprosy has been recognized as a major public health problem and anti-leprosy activities are being carried out.

Having analysed the overall results of leprosy control in the last 17 years during which WHO has been involved it appears that the number of registered cases represents only 42% (Table 1a) of the estimated total and this figure is well below target. Some 16% of registered cases are still institutionalized. Concerning treatment and in particular *regular* treatment, although data are difficult to obtain, it is obvious that regularity of attendance for treatment generally has not reached accepted standards.

(2) The problems in leprosy control are fully recognized—the relatively high proportion of multibacillary patients representing a potential reservoir for continued spread of the disease, e.g. in Fiji over 20 per cent of lepromatous cases are children and young adults."

[In view of the fact that only 42% of the estimated cases in this vast area have been registered, and the known deficiencies in trained staff who might be able to find and treat more cases, or supervize others in doing so, one wonders how the therapeutic advice in this interesting report will ever be applied in practice. In Annex 1, page 5, it is difficult to understand the arithmetic on the number of rifampicin capsules needed per year, with regard to the cost in brackets, Clofazimine is printed as 600 mg, which should surely be 100 mg, in the first column.]

A. C. McDOUGALL