

## CONSIDERATIONS IN THE INTEGRATION OF EYE CARE INTO LEPROSY CARE SERVICES

Sir,

Courtright & Lewallen<sup>1</sup> rightly draw attention to the often neglected subject of the integration of eye care into leprosy services. I would like to comment on their selection criteria for the need of an eye-care programme within a leprosy-control programme.

A common and easy to recognize eye complication in leprosy, with good prospects for treatment, is lagophthalmos due to facial nerve damage. Most lagophthalmos is the result of reversal reaction in borderline patients (BT, BB, BL) and occurs either before registration or shortly (within 6–12 months) after the start of antileprosy therapy,<sup>2</sup> that is early in the disease and among young patients. At least half of such patients belong to the paucibacillary BT group. Overall, facial nerve damage, will exist or develop in 2–3% of all newly registered leprosy patients, in spite of multidrug therapy (MDT).

Elderly patients with a long history of disease will often show multiple and chronic eye complications due to leprosy, but alas it is true, that apart from possible cataract extraction or lid surgery for lagophthalmos, usually not much can be done. In general no new eye complications due to leprosy will appear in this group of patients, but it is certainly useful to screen them for treatable conditions.

A long delay between disease onset and commencing antileprosy treatment may result in more eye complications, but any MB patient may develop ENL with associated acute iridocyclitis or sclerouveitis, which, although rare, is a potentially blinding complication.

General eye diseases, such as senile cataract or trachoma, may well be responsible for half of the visual impairment and blindness in leprosy patients of all classifications. National and regional data on blindness will also give an indication of the existence of such eye diseases among leprosy patients.

The criteria, as mentioned in the article,<sup>1</sup> could therefore give the false reassurance to programme managers that there is no need for an eye care programme, because the majority of their patients are paucibacillary (as in most of Africa for example), or because they have rarely 'cured' patients over 50 years old, or with a disease history of more than 25 years while they are under their care, or because patients usually present with only a short delay between symptom onset and treatment commencement.

Any leprosy control programme should devise a step-by-step system for the treatment of eye complications taking into account the local situation, and starting with the peripheral leprosy fieldworker, via the paramedical leprosy supervisor to either the referral leprosy hospital or directly into the eye care services via the eye nurses and ophthalmic assistants towards the ophthalmologist. It should be kept in mind that the patient should be treated as near home as possible.

The leprosy fieldworker and the leprosy supervisor should be the frontline workers in this system and be trained in the recognition, treatment, follow-up, or referral of patients with lagophthalmos, 'the red eye', blindness due to cataract and the other most common eye diseases. These workers should, among others, have access to antibiotic eye ointment, for immediate treatment of conjunctivitis and early corneal ulcer. Eye-lid surgery should be made possible in the referral leprosy hospital and cataract and other surgery in the nearest hospital that has the necessary facilities.

It is true that some workers in the ophthalmic community may have to be motivated, involved and additionally trained in order to care for leprosy patients. To create good relationships, and to break any prejudice against leprosy that may still exist, it may be of help if leprosy programmes welcome eye workers in training for some studies or practical work in the relevant setting.

The Netherlands Leprosy Relief Association has been working along these lines for many years in the programmes it supports.

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## References

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- <sup>2</sup> Naafs W, Wheate HW. The time interval between the start of anti-leprosy treatment and the development of reactions in borderline patients. *Lepr Rev* 1978; **49**: 153-157.