REPLY: CONSIDERATIONS IN THE INTEGRATION OF EYE CARE INTO LEPROSY CARE SERVICES

Sir,

We are grateful for the comments and discussion by Dr M. Hogeweg regarding integration of eye care and leprosy care services. Our suggestions for defining the minimum criteria for the establishment of an eye-care programme are based on 2 assumptions: (1) in most leprosy-control settings access to eye-care services will be limited and we must try to formulate criteria which will apply to the bulk of patients with potentially blinding eye disease; and (2) programme managers need a rapid and relatively accurate method for assessing the needs for the development of a specific programme to address the eye-care needs of patients.

As Dr Hogeweg points out, in India only 2–3% of newly registered paucibacillary patients have or develop nerve damage resulting in lagophthalmos and/or ectropion.[1] She further points out that most lagophthalmos develops during reversal reactions occurring within 6–12 months of the initiation of MDT. Proper treatment of reversal reactions by systemic steroids, intended to reduce all nerve damage and deformities, has been shown to reduce the development of lagophthalmos by 75%.[2] We assume (*hope*) that this treatment will be part of any good leprosy-control programme even if special attention is not given to eye care. Lagophthalmos is not uncommon in multibacillary patients although the lack of proper population-based studies limits our ability to generate estimates. Steroids will not help these patients but surgical intervention will. They are likely to be neglected if considered 'cured' by the leprosy control programme.

The majority of blindness in leprosy patients, as in all blind patients, is caused by a cataract. There is strong evidence that multibacillary patients with chronic uveitis develop cataracts both at a younger age and more frequently than the general population.[3–5] Therefore, we have emphasized the importance of eye care in the group of patients > 50 years of age, with multibacillary disease, and with a history of leprosy > 25 years. Although, as Dr Hogeweg points out, there is currently little we can do to avoid chronic uveitis and cataract in these groups, the cataracts can be removed and blindness cured.

We would regret it if programme managers decided there was no potentially blinding ocular pathology in their leprosy patients based on the minimum criteria we presented; a proportion of patients will always require ophthalmologic intervention.

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