PROPORTION OF BENEFICIARIES VS RELAPSE IN MDT PROGRAMME

Sir,

The recent review on the risk of relapse following WHO recommended multidrug therapy (MDT) revealed that this rate 9 years after stopping MDT[1] is very low, namely 0·77% for multibacillary (MB) and 1·07% for paucibacillary (PB). In comparison to dapsone monotherapy, this risk is lower by 10 times. This indicates that the rest of the patients without relapses had fully benefited from MDT.

In a time bound by a public health programme of a gigantic magnitude and carried out under constraints of limited resources with a target of the elimination of leprosy, it is important for the programme managers and clinicians, especially dermatologists managing leprosy, to consider first that a large number of patients benefited from MDT over a period of time rather than that a small number of patients are likely to pose a clinical problem such as relapse. Once the magnitude of the problem reduces to a nonpublic health level, these nonresponders to MDT could be considered as a special entity. Even the small numbers of relapses when they occur could be effectively controlled. During the smallpox eradication drive, even though vaccination in general population was marked by mortality due to encephalitis, the vaccination programme was continued even at the cost of a few deaths. The end result was global eradication of smallpox. A similar approach should be followed in a leprosy programme, if we want to achieve global elimination only with MDT. We present two tables which highlight the benefit offered to a large section of patient population belonging to MB and PB types.

To understand the net outcome from MDT intervention, which is a mass programme, the

Table 1. MB leprosy patients benefited from MDT

MB cases	100	1000	10,000	100,000
Relapses	0·7	7·7	77	770
Beneficiaries from MDT	99	992	9,923	99,230

Table 2. PB leprosy patients benefited from MDT.

PB cases	100	1000	10,000	100,000
Relapses	1·07	10·7	107	1070
Beneficiaries from MDT	99	989	9,893	98,930

following theoretical projections were made to demonstrate possible relapses as opposed to beneficiaries of the MDT based on the calculation of risk of relapse by WHO.[1]

The number of relapses calculated is over a period of 9 years as per the WHO calculation of relapse rate.[1]

These types of simple calculations in absolute numbers instead of percentages would be useful for training field workers.

It may be relevant in this context to point out that in view of negligible relapse risk rate after WHO–MDT, WHO considers that annual surveillance examination of patients after the end of treatment may not be required and patients are to be educated to report if they develop any clinical events.[1] This procedure, however, is not yet adopted by most control programmes.

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Reference

[1] Risk of relapse in leprosy. Paper prepared by the Leprosy Unit, WHO 1994.