medical colleges in Mumbai indicates that teaching of leprosy is grossly inadequate in all colleges, reference books on leprosy are not available in college libraries and proper information about national leprosy programme explaining the existing leprosy status in the country is not available to the students. Though improvement in the standard of teaching of leprosy in medical colleges is a high priority in India against the background of the WHO target of leprosy elimination in 2000 AD, no systematic efforts are being made in this direction at the national level. A few sporadic efforts in this context have been documented by some voluntary organizations.

Hind Kusht Nivaran Sangh-Maharashtra Branch attempted to involve non-allopathy medical colleges in Maharashtra in leprosy work. Leprosy teaching in such colleges is virtually negligible or not up to acceptable standards. Medical graduates passing out from these medical colleges generally set up their private medical practice at the grass roots level, catering to low socio-economic groups, among which the possibility of detection of leprosy cases is relatively greater.

In Maharashtra, there are 37 ayurvedic, 37 homeopathic and five unani medical colleges where approximately 4000 new admissions take place every year. In 1992, collaboration with these medical colleges by organizing teaching sessions on leprosy to medical students was initiated. The teaching was ‘task orient ed’, giving greater emphasis on diagnosis, treatment of leprosy with special reference to elimination strategies and practical clinical demonstrations of leprosy patients. In the initial stages, teachers were leprosy experts and dermatologists practising in local situations. Subsequently, training in leprosy for teachers in non-allopathic medicine colleges has been completed and adequate teaching material has also been provided to them. This has helped to maintain the continuity of teaching of leprosy in those colleges which were willing to cooperate. As such, 39 medical colleges have been covered during the last 5 years and almost 1200 students have received the benefit of leprosy teaching every year.

Follow-up of these students was maintained by correspondence. These young, enthusiastic medical personnel were kept in touch with the subject by the provision of literature on recent developments in leprosy. A questionnaire study revealed that graduate students who succeeded in obtaining jobs, as well as those who started private practice, detected 351 new leprosy cases during the last 5 years. Help with diagnosis and treatment has been provided for all cases by trained staff belonging to the government and non-government sectors. This experiment indicates that involvement of non-allopathy medicine colleges is a fruitful method for case detection in India.

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Reference


COMMENT: SENSORY TESTING OF THE HANDS IN LEPROSY

Editor,

I have been reading the letter to the editor by Saunderson, Currie, Gabre and Byass [*Lepr Rev*, 1997; 68: 252–254] and comments by van Brakel and Anderson [*Lepr Rev*, 1997; 68: 382–383] with interest. What is missing in the letter from Saunderson *et al.* is a clear description of the history and clinical findings of the 11 out of 12 patients, of which they present the results of long-term follow-up. Had those 11 patients at diagnosis a history of recent nerve function impairment (NFI) or one of longer duration (more than 6 months)? Were there other complaints like nerve pain, numbness, paraesthesia, recent
weakness? Were there other signs of a severe reaction? Were there signs of atrophy? From the data available, it seems that at least some of these 11 patients did not suffer from a recent NFI, but most likely had already an NFI of longer duration. As such, in general, no major changes in nerve function are expected (except of course when developing new signs of a severe reaction or silent neuritis). The point they want to make would have been better served if only patients with a recent NFI would have been selected for follow-up.

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Editor,

Thank you for the opportunity to respond to Dr Schreuder’s comments.

At issue in this discussion is the definition of nerve function impairment (NFI) in leprosy and its correct management. When patients have unequivocal signs of recent NFI, such as nerve tenderness, weakness or sensory loss, with or without signs of a reversal reaction, it is clear that steroids are the treatment of choice. It is possible, however, to use more and more sophisticated techniques to look for early or minimal signs of NFI: these include the assessment of autonomic nerve function and better methods of sensory testing, especially the use of standardized nylon monofilaments.

The question we are interested in is: how important are minimal signs of NFI discovered by these newer techniques? Do they indicate the imminent onset of more serious NFI which could be prevented by steroid treatment, or do they suggest a common, but mild and perhaps self-limiting neuritis with a good prognosis? It is conceivable that every leprosy patient would show some degree of nerve involvement if we had tools sensitive enough to detect it.

The clinical details of the 12 cases we reported are available. At diagnosis, four had normal hands and eight had some degree of loss of sensation (LOS) to the 10 g filament. Three received steroids at diagnosis for recent NFL Thus many of the study group had previous NFI, but during the study they developed new NFI detected by the 1 g filament.

The filament study itself was not started at the time of diagnosis, but looked at patients already enrolled in another long-term study of the results of MDT. We believe that all patients on MDT are at some risk of developing neuritis, and the original study examined 159 patients prospectively for several months, with 19 meeting the standard criteria for steroid treatment for recent NFI.

The 12 patients we re-examined 5 years later were chosen precisely because they did not fit the standard criteria for NFI and were not treated with steroids, but they did show signs of new sensory loss when tested over a period with the much more sensitive 1 g filament. Thus we were looking at cases of presumed recent, minimal, silent neuritis. We found that 11 of the 12 did not develop further damage on long-term follow-up. The 12th patient did develop more sensory impairment and was treated later with steroids.

Our main point is that the use of very sensitive methods of nerve function assessment may lead to unnecessary over-treatment with steroids.

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Reference