

REPLY

Editor,

Thank you for giving me the opportunity to respond to the letter submitted by Buddingh and Idle. I would like to make the following comments.

I would like to thank Buddingh and Idle for their comments on our paper titled 'Grading impairment in leprosy'. In general, I agree with what they are saying, but it gives me the opportunity to emphasize a few of the points, some of which were already made in the paper.

1. The WHO impairment grading system has several serious shortcomings. The units of measurements are crude and, even when summed as the EHF score, the scale is not very responsive to change. Large changes in impairment may not be reflected in the score. The latter may happen when limbs have already reached their maximum score (2), or when some limbs improve while others deteriorate.
2. Severity of impairment as measured with the WHO grading does not necessarily correlate well with the limitation in activities of daily living experienced by the person. However, this is likely to be more of a problem when the maximum score is used as an indicator of severity than when the EHF score is used.
3. The strength of the WHO grading system is its widespread use. Buddingh and Idle state that it is unlikely to be possible for integrated programmes to monitor POID activities using systems that record impairments in more detail. The 'output' or process indicators they suggest may be very relevant, but their widespread introduction would take quite a few years to accomplish. Meanwhile, we should try to make the best use of what is already being recorded. In our opinion, as an indicator, the EHF score makes better use of the WHO grading data than does the maximum score. Its main advantage, as confirmed by Buddingh and Idle, is a greater responsiveness to change.
4. Point 5 in Buddingh and Idle's letter is in itself true. However, it is not a shortcoming of the WHO grading system, but of the tests underlying the system. It will be difficult, if not impossible, to find tests of better accuracy and reliability than those commonly used in sensory testing and voluntary muscle testing, if they are still to be suitable for field use. Imperfect accuracy of screening and diagnostic tests is a reality that one needs to accept in public health.
5. I disagree with the statement 'the impairment score does not reflect the severity of the impairment'. The EHF score does reflect extent of impairment, which is usually correlated with severity. Note that this does not mean severity in this sense of what is perceived by the person affected as severe. Perceived severity is more likely to be correlated with activity limitations and restriction in social participation. However, when one is monitoring prevention of impairment activities or a prevention of impairment programme, it is appropriate to use an indicator that reflects simply severity of impairment.
6. Buddingh and Idle state that 'changes in the score may not reflect changes in actual impairment'. While there may be instances when this is true, for example due to spurious test results, this is not normally the case. The opposite is more likely to be a problem as argued in comment one above.
7. In my opinion, the meaning of a particular score is no more or less clear in the EHF score than in the maximum score. At least, when using the EHF score, one knows that all four limbs and both eyes have been taken into account in the score.

Use of the EHF score must never lead to a false sense of accuracy and keep us from trying to improve on what we have got. Let us join hands in searching for better and more meaningful measures and indicators to monitor and evaluate POID activities and programmes, while making the best use of available data in the meantime.

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