The Eleventh International Leprosy Congress
Mexico City
November 13–18, 1978

"There are too many of them, and they are too big. They are also too expensive. They serve no useful scientific purpose. For some people, they are a convenient tax-deductible expense; for others, they provide social and travel opportunities and attractions." Whatever their shortcomings and their deficiencies, they—congresses and conferences, seminars and workshops, call them what you will—are still with us. And November 1978 will see the Eleventh International Leprosy Congress, to be held at the Medical Center, Mexico City, from 13 to 18 November.

The President of the International Leprosy Association, Dr. Jacinto Convit, appointed soon after the Bergen (1973) Congress a small Advisory Committee whose main activities initially were to ascertain from the members of the Association their views on the content and format of the next congress and to make recommendations to him based on their enquiries. The many suggestions received were very carefully considered by this committee which met in Mexico City in January 1977. The interest shown by the members is reflected in the number and variety of the ideas submitted. Of course, some of these suggestions cancelled each other out; others were too individualistic and would have appealed to a very limited proportion of participants; some would insist that all presentations be made in English, while others wanted simultaneous translation at every session in three or more languages. Many urged that adequate time be allotted for discussion, while the more realistic admitted that many would-be participants would not be able to obtain travel grants unless their proffered paper was accepted.

The principle that guided the President's Advisory Committee in their decisions was the greatest good of the greatest number. With such a range of scientific and social interests as is represented by our membership, the committee cannot expect to please "all the people all the time," but it is hoped that participants will appreciate that while it is impossible to reconcile the irreconcilable, the compromises reached will be seen to be in the interests of the majority.

There will be several departures from tradition: notably, there will be invited papers by selected authors who have made recent major contributions in their field. These will in the main consist of review presentations, with the object of bringing up to date participants who will value an authoritative didactic summary. This more structured approach will necessarily and unfortunately reduce the time available for "free presentations," but the clock is a stern arbiter.

Another innovation is "poster sessions" which have been proving attractive at similar congresses. Participants who have something important to say are invited to say it in posters and to display their posters during a designated period. They will have an opportunity of talking to their posters and thus sharing with a proportion of those attending their findings.

More important than administrative details, and more significant than the reporting of the latest research findings, will be the continuing influence of the congress on our thinking about leprosy and what we do in the light of the new knowledge and new constraints. The euphoria of the early days of the sulfone era, and the measured optimism of ten years ago, are being replaced by a more sober realism. The old difficulties are still there and they have been augmented by the problems of drug resistance and persister organisms. Irregularity of treatment and low standards of patient compliance, even in the best programs, seem to be ever with us. Deformity is still occurring and preventable complications are not being prevented. Prejudice and stigma are diminishing with painful sloth. The leprosy problem must be taken more seriously now by governments and voluntary agencies, the World Health Organization, and by research workers generally.

The Eleventh International Leprosy Congress will justify itself, and all the organization and expense will prove to be worthwhile if a more determined attack can be made on the disease, an attack compounded of scientific competence and humanitarian concern.

Of specific problems and specific debates there will be many, for claims and counter-claims have been recently made on many aspects of leprosy including, for example, microbiology, immunopathology, therapy (including drug resistance and immunotherapy), the occurrence of "leprosy" in the wild armadillo, and the pros and cons of integrating leprosy into programs of community health care.

We have had some good therapeutic tools for three decades now. Perhaps we have not always used them wisely and we have certainly not used them on a wide enough scale. The Eleventh International Leprosy Congress should afford all the participants many opportunities for learning, for self-criticism and for the re-assessment of the gravity and urgency of the problem of leprosy in the world.

—STANLEY G. BROWNE, M.D., O.B.E.
Secretary-Treasurer, ILA

16 Bridgefield Road
Sutton, Surrey, England

Sulfone Resistance and Leprosy Control

The emergence of sulfone-resistance is bringing a complete reappraisal of leprosy therapy. Several meetings and reports have recently emphasized the need for strictly controlled high dosages of sulfones and in certain cases combined chemotherapy. The WHO Leprosy Expert Committee on Leprosy (1976) has issued precise recommendations which can be summarized as follows:

1. In order to prevent the emergence of secondary sulfone resistance, the treatment of newly diagnosed cases should be based on dapsone commenced, maintained and continued regularly in full dosage and without interruption irrespective of lepra reaction.
2. Initial combined therapy with sulfones and second-line drugs should be given to lepromatous (LL) and borderline (BL, BB) cases.
3. Combined therapy with second-line drugs should be used for cases with confirmed or suspected dapsone resistance.

These recommendations have been amplified and detailed at recent workshops held in Manila (1977) and Jakarta (1977) at the initiative of the Sasakawa Memorial Health Foundation, and at the joint meeting of ILEP (International Federation of Anti-Leprosy Associations) Medical Commission and LEPRA Advisory Board in Heathrow (1977).

The basic problem however is that there is much more in sulfone resistance than a simple problem of therapy. The emergence of resistance obliges us to reconsider drastically our strategy of leprosy control. The issue is not to find the best regimen to suit individual patients in hospitals, it is to design the best strategy to prevent resistance when treating large numbers of patients, that is patients by the thousands or the hundreds of thousands.

There is no doubt that sulfone regimens as applied for the last 20 years, and especially during the last 10 years, have been largely based on convenience. Leprosy treatment had to be cheap, it had to be administered unsupervised by auxiliary workers, it had to be delivered in far away villages, it had to be free of toxicity and undesirable reactions. All this was quite consistent with the need of treating millions of patients in countries with poor health resources, insufficient manpower and limited facilities. The sulfones remarkably fulfill these conditions. Mass treatment of ambulatory patients could thus be organized. In a number of countries it was responsible not only for the cure or at least considerable improvement of many patients, but also for a marked decline of incidence. Where no dispensaries existed and local conditions precluded the deployment of mobile teams, self-medication was instituted. Patients traveled days and weeks to get their monthly or quarterly supply of dapsone.

Convenience however was the *leitmotiv*. From a fortunate logistic context it tended to transform into a myth to which leprosy had to adhere. Since very high dosages administered at the beginning of the sulfone era were in all likelihood associated in leprosy patients with a high incidence of lepra reaction and other complications such as dermatitis and psychosis, lower doses were recommended, which relaxed the requirements for