Efforts to create a broad interest in the social problems of leprosy have been effective in the field of public health, especially within that element directly involved in the disease. Impact elsewhere has been limited. *Elephantiasis graecorum* (as a name for leprosy) arose in the second century, to flourish many hundreds of years within the profession, never among laymen. As a forerunner of the eponymic "Hansen's disease," it effectively bypassed the stigma of leprosy. Perhaps, as Unamuno remarked, it was "something like the doctors' habit of giving names to something they can't cure.[2]"

Whereas acronyms abound within medical jargon, almost creating a lingua franca, eponyms are out of current fashion, leaving "Hansen's disease" editorially awkward, convertible into many foreign tongues with difficulty. While providing a sharp stimulus to social improvements in leprosy, the social impact is only one of leprosy's many faces, which can improve the most along with the others, not by itself alone.

Heaping poxes and plagues upon our enemies, once popular pejoratively, is no longer a practice. When diseases which enjoyed those names became treatable and preventible, the fever subsided. The pest that was once the plague is now a minor annoyance or an insect feeding upon our garden roses.

The time has come to emphasize that leprosy is now effectively treatable, even if not perfectly so. This needs to be publicly exaggerated.

Substantially a rural disease with an impoverished face, the deficit in securing treatment to the patient remains enormous. In the rich man's country, leprosy is really not much of a problem, medically or socially. But where poverty and poor roads prevail, delivery of adequate care in rural regions, where most leprosy is to be found, requires heavy financing and mobility. The personnel can be found. More than a thousand of the dedicated registered at the recent XI International Leprosy Congress in Mexico City, 13–18 November 1978. Although leprosy is far from eradication, money, medicine, and time can eliminate social difficulties where they exist.

The treatment of patients in specialized hospitals or clinics needs to be abondoned in favor of care for the patient in his own community. This is an obviously strong statement, when speaking of communities where little of any kind of medicine is available for anything. Yet the open hospital is enough for short term patient care, the dermatological or surgical clinic for the outpatient, the nursing home for the invalid.

Leprosy ceases to be communicable when adequately treated, no more transmissible than acute appendicitis. Let the patient's habitation be strictly within, not outside, the camp. The leprosarium, which began in the 9th century, flourished in the Middle Ages, but has become an outdated type of facility. With the correct assignment of leprosy to general medicine, much of its incongruous social face should vanish.

—George L. Fite, M.D.

Bethesda, Maryland

—Paul Fasal, M.D.

San Francisco, California

Has Leprosy Come of Age?

Much as I appreciate the outstanding contributions of the authors, the guest editorial, "Leprosy Comes of Age," reflects a more fortunate perspective than most of the world can boast, for in it I see the viewpoint of Americans who live in a country where medical standards are high and the incidence of leprosy is miniscule. Logically enough, therefore, it is understandable that leprosy holds little interest to the "intelligent layman or for the average practitioner of medicine."

In Europe and North America, the medical problems are more typical of an indus-

trial society with uncrowded housing, a high level of sanitation, uncontaminated foods, general prosperity, and long life expectancy. Regrettably, this is but a small part of the world, and the prevalence of leprosy and the concern for it are of vital interest to the layman and medical worker in vast areas of our globe. Since leprosy has a strong relationship to social and economic development, we must recognize that we do not have the economic resources, let alone perfected medication, to achieve complete eradication of the disease. To permit complacency in light of the estimated total of 12–15 million people afflicted with leprosy would be utterly unrealistic.

We must accept the fact that leprosy will be integrated into a total health program in the emerging nations in which leprosy is so prevalent. This has received top level agreement by the Ministers of Health in many countries, but they have set a time schedule which is probably unattainable because of a lack of adequately trained medical and paramedical personnel. For example, the results of a recent survey of 106 medical schools in India indicated that during the period of medical training, the average time spent on leprosy is 4½ hours during the three year period! If this is true, in this country where more than one quarter of the world's leprosy is to be found, any complacency would be a disservice to the afflicted and make impossible a properly integrated health delivery program.

It should also be said that the integration of leprosy requires the continuation of specialized personnel, if not institutions, to deal with leprosy complications—especially trained physiotherapists, orthopedic surgeons, shoe specialists, prosthetic technicians, etc., are required to avoid or correct deformities. If anything, our work becomes more complicated not only for those who were in Mexico City but for a host of others from this generation and generations to come.

—Roger K. Ackley

Bloomfield, New Jersey

Notes on 47/4

For the careful reader, a number of changes are apparent with this issue of the JOURNAL. In keeping with the present constitution of the International Leprosy Association and as discussed in the minutes of the recent JOURNAL Board of Directors meeting (this issue, pp. 621–623), this issue does not include a listing of Associate Editors.

Customarily, the Subject-Author Index has appeared in the December issue. Because of the continuing need to meet mailing deadlines, we have been unable to include this year's Index in the present issue. It will be included as a Supplement to the March 1980 issue. While its unhurried preparation will hopefully result in a more complete and useful Index, we apologize for any inconvenience created for those wishing to have their JOURNAL issues bound promptly.

Finally, this issue contains the abstracts of the U.S.–Japan Cooperative Medical Science meeting held on 24–26 September 1979. Customarily, although not always, these abstracts have appeared in the March issue following the Fall meetings. Hopefully, this more rapid publication will be helpful.

—RCH