Although we had decided to reduce the starting dose of dapsone given in MDT, because of this further fatal reaction the Disease Control Committee of the Department of Health in Vanuatu has recommended that dapsone should no longer be used in Vanuatu. Unfortunately, there is limited experience of the effectiveness of combination MDT regimens not using dapsone ([6]), but after discussion with the regional WHO consultant it has been decided to continue with MDT substituting ethionamide, or if intolerance to ethionamide occurs, minocycline, for dapsone.

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On Reflections on the Elimination of Leprosy

TO THE EDITOR:

In the interesting editorial "Reflections on the Elimination of Leprosy" (IJL 1992: 60:71–80), Fine notes that "the easiest way to reduce the prevalence of cases on treatment is . . . to shorten their course of treatment." If, in Malawi, we stopped the treatment of multibacillary leprosy patients at 24 months, rather than our current practice of treating until the bacterial index of skin smears has become zero, the prevalence rate of leprosy per 10,000 population would have been 1.13 in December 1990 and 0.94 in December 1991. It may, therefore, appear that leprosy has been eliminated by December 1991 as a public health problem within the borders of the Republic of Malawi.

But, as an example of the "number-dancing" in relation to the question, "What population?" as predicted in the editorial, one should realize that among the estimated 1 million Mozambican refugees currently residing in Malawi, the prevalence rate of leprosy (even assuming stopping the treatment of multibacillary patients at 24 doses) is still 2.06 per 10,000. This group of refugees is concentrated mainly in the two most southern districts of Malawi. Surely leprosy has remained a public health problem, at least in some parts of the country or in some subgroups of the population?

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