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CORRESPONDENCE

This department is for the publication of informal communications that are of interest because they are informative and stimulating, and for the discussion of controversial matters. The mandate of this JOURNAL is to disseminate information relating to leprosy in particular and also other mycobacterial diseases. Dissident comment or interpretation on published research is of course valid, but personality attacks on individuals would seem unnecessary. Political comments, valid or not, also are unwelcome. They might result in interference with the distribution of the JOURNAL and thus interfere with its prime purpose.

"Guide to Eliminate Leprosy as a Public Health Problem" (First Edition, 2000, World Health Organization)

TO THE EDITOR:

The World Health Organization (WHO) has recently published a "Guide to Eliminate Leprosy as a Public Health Problem." This guide was distributed to the participants at the meeting held in Maputo last September on Intensification of Elimination Activities in the African Region. The objective is that this Guide will be widely distributed, after local adaptation, in the most endemic countries.

This guide is beautifully presented, with very clear pictures, and can certainly contribute to disseminate knowledge about leprosy and the basic ways to tackle it. In that sense, it incontestably fulfills a need, and we can only applaud the initiative.

I am, however, afraid that it is much too simplified in some aspects, and can thus be a source of errors or of services below minimal acceptable standards. My main concerns relate to the following aspects:

Signs of leprosy: it is said that "a leprosy patient is someone who has a skin patch or patches with a definite loss of sensation, and has not completed a full course of treatment with multidrug therapy." Anesthetic patches are of course important but if leprosy is only suspected in case of anesthetic patches, then the most infectious cases will not be diagnosed and transmission will not be reduced; it is well mentioned that "other signs of leprosy include reddish or skin-colored nodules or smooth, shiny diffuse thickening of the skin without a loss of sensation," but if it is not said that in these cases it is necessary to refer the patient to confirm the diagnosis, possibly through slit-skin smear examination, it could lead to gross overdiagnosis. It is certain that the existence of a high-quality laboratory for smear examination is not a prerequisite for introducing MDT services, but discarding smear examination altogether is going too far.

It should be clearly mentioned when to refer difficult cases, not only for diagnosis but also in case of complications.

Until now, the general rule was that the monthly dose intake should be supervised at the health center. Some exceptions were possible for patients living far away, or during the rainy season, or in other special conditions. For these patients, several months of treatment could be given at a time. It was then said to try and make a reliable person from the neighborhood of the patient responsible for the supervision of the treatment. Now, there is a strategy called "accompanied MDT" which, I fear, is going too far. If it is simply asked systematically of all the newly detected patients whether they prefer to collect their treatment from the health center at regular intervals or to take all the blister packs with them, we can expect that most patients will prefer to receive the whole treatment at once; it looks so much easier. It is even

possible that most of the health staff will favor that possibility; it discharges them from their responsibility and means much less work for them. Treatment will not be supervised at all. So, there is no chance to know whether the patient still takes the drugs or not, and in which way. Will he be sufficiently convinced, after his single visit to the health center, of the importance to treat himself regularly for 1 year? If he stops his treatment, the health staff will have no way to know it. Will the patient have clearly understood what is expected from him, what are the possible complications and what he is supposed to do in case of new symptoms? No contact with the patient any more during his treatment means reduced chances to detect reactional episodes, to emphasize messages, or to educate on how to avoid new disabilities.

There is no mention of peripheral nerves examination, nor of voluntary muscle testing or sensory testing.

It should be clearly mentioned what is the target audience of this booklet.

I hope that these remarks can help the National Leprosy Control Programme Managers decide on what adaptations they will bring to this Guide before it is widely distributed in their country.

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Facial Lesions Resembling Leprosy

TO THE EDITOR:

Leprosy is a chronic granulomatous disease which leaves deformities if not treated early and adequately. The manifestations of early lepromatous leprosy and its late complication of nasal deformity are well-described ([4]). However, the diagnosis of leprosy should not be established when convincing evidence is not found because leprosy still carries significant stigma in the society, despite years of health education campaigns. Two patients, one with presenile sebaceous gland hyperplasia and the other with late yaws, who were believed to have leprosy, are reported.

CASE REPORTS

Case 1. A 61-year-old Chinese male was referred to the skin clinic as a case of lepromatous leprosy with "leonine facies." He had bright, erythematous rashes on the face, especially on the cheeks, forehead and earlobes (Fig. 1). The face was "oily" with loss of hair on the lateral aspects of the eyebrows. There was thickening and furrowing of the forehead. Sensory and motor functions of the face were intact. There were

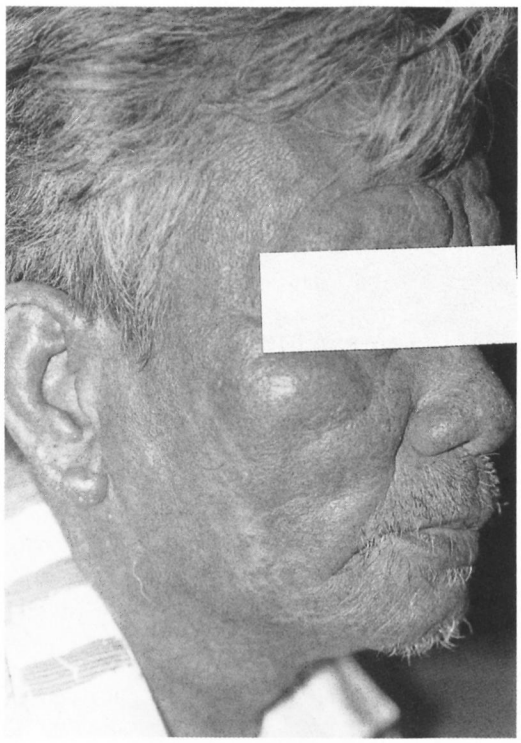

FIG. 1. Erythematous rashes on the face. Note thickening of the earlobe and furrowing of the forehead.