

## Leprosy in the era of integration

Sir,

Leprosy has been a major public health problem of the developing nations in the last century. Leprosy control programs were initiated in the year 1955, which were based on dapsone monotherapy. Multidrug therapy was initiated in the year 1982.<sup>[1]</sup> In 1993, the National Leprosy Elimination Programme (NLEP) was initiated with the goal of decreasing the prevalence rate of leprosy below 1 case/10,000 population. India has achieved elimination of leprosy as a public health

problem in December 2005 by recording a prevalence rate of 0.95/10,000 population and subsequently it has further declined to 0.84/10,000 population as on March 2006.<sup>[2]</sup>

The aim of present study was to analyze the epidemiological and clinical data of leprosy patients presenting to our department over the last 4 years (2004–2007) and to assess the changing trends, if any, during the NLEP (2004–2005) and the post-NLEP phases (2006–2007). In the post-NLEP phase, community surveillance, slit skin smears, distribution of multidrug therapy, deformity prevention and management performed by leprosy workers during the NLEP phase were discontinued. Leprosy services have now been integrated into the general healthcare system viz. primary health centers and municipal dispensaries.

We retrospectively evaluated all new cases of leprosy presenting to our department in the period 2004–2007. The patients were divided into two groups: those presenting during NLEP (2004–2005) and those presenting post-NLEP (2006–2007). The data was analyzed taking into consideration the demographic data, type of leprosy, number of patches, number of nerves and presence of any deformities, impairment or reaction.

Total number of cases (2004–2007) were 297, of which 101 cases (group 1) were seen in the NLEP phase (2004–2005) and 196 (group 2) in the post-NLEP phase (2006–2007). The average age of presentation was 32 years in both the groups. The average duration of disease was 26.7 months in group 1 and 19.2 months in group 2. Males outnumbered females in both the groups (3:1, 4:1). Although there was an actual increase in the number of patients, clinical pattern of disease presentation remained unchanged. Two-thirds of the patients belonged to the tuberculoid side of the leprosy spectrum. In borderline tuberculoid leprosy, patients with six or more than six patches increased from 30% (30/101) in the NLEP phase to 70% (136/196) in the post-NLEP phase. This reflects the fact that the patients with more florid lesions who were earlier identified by the field workers were now only diagnosed at tertiary centers. Approximately 70% of the patients had more than one nerve thickened in both the groups. Lepa reactions were observed in 13 and 9% of the patients and deformities in 3 and 6% of the patients in groups 1 and 2, respectively.

Hence, it is clear that the number of leprosy patients reporting to our department since 2006 after the end of NLEP has doubled as compared with the earlier 2 years. This is directly related to the discontinuation of community surveillance and management, which was a feature of NLEP.

The end of NLEP signifies the elimination of leprosy as a public health problem in India. However, we expect the numbers of leprosy patients presenting to dermatologists in both private practice and teaching hospitals to keep increasing in the future as peripheral surveillance activities are discontinued. This would require a specialized focus on early diagnosis, complete treatment and detection and management of disabilities. Also, multidrug therapy should be made available at the tertiary care centers rather than being available only at primary health centers and municipal dispensaries for prompt initiation of therapy.

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**DOI:** 10.4103/0378-6323.48675 - **PMID:** 19293515

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