

## NEWS AND NOTES

*Information concerning institutions, organizations, and individuals connected with leprosy work, scientific or other meetings, legislative enactments and other matters of interest.*

### 6 THIRD PAN-AMERICAN LEPROSY CONFERENCE<sup>1</sup> HELD IN BUENOS AIRES, DECEMBER 9-15, 1951

The Third Pan-American Conference on Leprosy, convened by the Ministry of Public Health of the Argentine Republic, was held December 9-15, 1951. The preparatory meeting was held in the forenoon of Sunday, December 9, at which the officers were elected, and the formal opening meeting was held that afternoon. The following were the officers of the Conference:

*President:* Dr. Leonidas Llano (Argentina); *Secretarios generales:* Drs. L. M. Bechelli (Brazil) and Ernesto T. Capurro (Argentina); *Secretarios adjuntos:* Drs. R. D. Azulay (Brazil), Jacinto Convit (Venezuela), Jonquieres (Argentina) and Brusco (Argentina).

The members attending numbered about 200, of which some 50 were from abroad. Fourteen countries were represented by one or more members, those from Brazil totalling 30; and two organizations were also represented, the International Leprosy Association (Dr. H. C. de Souza-Araujo) and the Pan-American Sanitary Bureau.

The ordinary scientific sessions and the committee meetings were held from Monday to Friday. Among the various other events, social and otherwise, were a courtesy call on His Excellency, the President of the Republic; a visit to the Sanatorio Baldomero Sommer, where interesting cases were examined and discussed; and a visit to the Preventorio "Mi Esperanza" of the Patronato de Leprosos. The closing plenary session took place on Saturday, December 15, at which among

---

<sup>1</sup> This report is a condensation of an extensive one provided by Dr. G. Basombrio, our Contributing Editor for Argentina; a full set of the reports of the committees was also kindly supplied by Dr. E. Agricola, of Rio de Janeiro. For consideration of space much has been eliminated, including the list of the honorary members and the members of the original executive committee, and details of formal meetings and of the entertainments and the hosts and special speakers on those occasions. Three of the five reports of the technical committees are reproduced, the translations not checked by the contributor.—EDITOR.

other things the reports of the technical committees were considered and approved. Only the chief delegates cast votes in any decision. Lima, Peru, was decided upon as the place of the next conference, to be held in 1955.

The official topics of the conference were as follows:

1. Classification of subtypes.
2. The reaction state (pathogenesis, therapy and prognosis) in the different clinical forms; its influence on the later evolution of the disease.
3. Reversibility of the clinical forms and of the reactions to lepromin.
4. Actual status of the antileprosy campaigns.
5. Social assistance to the leprosy patient and his family.

About 120 scientific papers were submitted, but for consideration of time only those were read whose authors were present. The following is a brief summary of the presentations.

*Classification of subtypes.*—Nine papers were devoted to this subject, the majority of them only of supplemental nature. Cochrane pointed out that the South American classification approved at Havana, based on immunology, is essentially polar, the so-called "incharacteristic" cases falling between the extremes. He believed that there should be created another clinical form, which he proposed should be called "atypical," to comprise the cases of difficult and uncertain definition. However, since the subject of the agenda was the classification of subtypes and not of clinical forms, it was concluded that for the present the suggestion of the British delegate could not be accepted. The only concrete papers presented in line with the official subject were those of Fiol and Basombrio and of a Brazilian committee. In general these two presentations coincided, and they formed the basis of the report of the committee which dealt with the subject.

*The reaction conditions.*—Seventeen papers dealt with this subject. Notable among them was one by Melamed, Fiol and Brusco on lepra reaction and the general adaptation syndrome, which opened new horizons with respect to the pathogenesis of this condition. Schujman, in a documented report, maintained that the intense reactions in the lepromatous form are, in the long run, favorable, a view supported by Basombrio, Fiol and collaborators from a survey made at the Sommer sanatorium. Also of much interest was the paper of Lauro de Souza Lima on pseudo lepra reaction, which gave in broad outlines the great experience of the author.

*Reversibility of the clinical forms and of the lepromin re-*

*action.*—Fifteen papers on this subject were read. A few of them dealt with the mutation of the polar clinical forms, noteworthy among those being one by Lauro de Souza Lima. From the general trend of these papers it appears that conversion is exceptional, and that it occurs only in the change from tuberculoid to lepromatous. The subject of the variations in the lepromin reaction was fully discussed. The majority of the papers centered on the discovery of the Argentinian leprologist, Fernandez, of the possibility of converting to positive, by means of BCG, patients who are anergic to lepromin, a fact which was given emphasis by the committee which dealt with this subject. Worthy of note for its scientific value was a paper by Olmos Castro on sensitization to lepromin experimentally induced in animals by BCG. [See page 221 of this issue.]

*The antileprosy campaigns.*—Although this subject was a last-minute addition, so to speak, by the authorities of the Ministry of Public Health, it was nevertheless fully covered, no less than 24 papers being read. From them, and from the report of the committee which dealt with the subject, it appears that in South America leprosy persists unabated and may be increasing, and for this reason the fight must be intensified. The subject of dispensaries was fully discussed, with emphasis on their indispensability in the campaign. Here also the question of BCG was taken up, in connection with the immunization of the healthy population.

*Social welfare.*—Fourteen papers on this subject were read, all of interest and profitable. There were those which were merely descriptive, reporting programs already under way, others which considered the economic protection of the patient and his family, and, lastly, others outlining programs yet to be realized.

*Miscellaneous subjects.*—Numerous papers on subjects not connected with the official topics of the conference were read. A majority of them dealt with therapy, especially by the parent sulfone and with TB-1. There were also some on histopathology in connection with diagnosis and classification, on bacteriology and experimentation, on sociology such as the paper of Fernandez Vautrai on sterilization and marriage, and others.

*Recapitulation.*—Despite the short time which the organizing committee had for the preparation of the conference, since

the necessary funds was released only late in July, it was a brilliant success, as shown by the considerable number of delegates present, by the many scientific papers submitted and their quality, and by the excellence of the reports of the technical committees. The positive accomplishments are as follows:

1. An excellent classification of the subtypes of leprosy, which in the next international congress will undoubtedly complete the classification approved at Havana.
2. The concept of the benefit of certain types of reaction in the lepromatous form, and an insight into the pathogenesis of this phenomenon with the syndrome of adaptation.
3. Clear and precise norms for the antileprosy campaigns, emphasizing especially the usefulness of the dispensary.
4. The fact that BCG vaccination, which makes anergic cases reactive to lepromin, offers hope for the immunization of the healthy population which is liable to acquire the disease, and perhaps also a future place in therapy.
5. The insistence that governments should promulgate just laws for social welfare, for the good of the patient and his family.

—G. BASOMBRIO

#### REPORT OF THE COMMITTEE ON CLASSIFICATION OF SUBTYPES<sup>1</sup>

##### GENERAL CONSIDERATIONS

In this classification the definitions of the forms of leprosy of the Fifth International Congress of Havana are taken into consideration.

In the first place, the Committee considers that a classification of subtypes, within a biological enumeration such as the present one, is a question of minor importance. In fact, the interest in a distinction by subtypes, or better by clinical forms, possesses a definite clinical and epidemiological value only with respect to certain aspects of the disease, such as the macular, neural and diffuse forms in the lepromatous type, and the torpid and reactional forms in the tuberculoid type.

For this reason we emphasize that the criteria adopted for the subtypes in the present report are: (a) clinical peculiarities, particularly the signs and symptoms useful for the individualization of the subtypes; and (b) topography, with special reference to the modalities of the neuritic manifestations.

The Committee suggests that, to the subtypes, there should be added the stage of the disease, with these designations: slight, moderate and advanced, and quiescent or residual.

The "reactional" form of the tuberculoid type must be well understood, since it includes not only the cases which comprise all of the fundamentals of this variety, and which are the majority, but also those which,

<sup>1</sup> *Presidente*, Prof. Luis E. Pierini (Argentina); *relator*, Dr. Nelson de Souza Campos (Brazil); *miembros*, Drs. Orestes Diniz, Azulay, Tiant, Cochrane, Basombrio, Garzon and Gatti; *supentes*, Drs. Baldino, Tello, Iglesias and Fraga Lima.

whether *ab initio* or in course of successive outbreaks, present aspects of transition toward the lepromatous form, these constituting the borderline (*limitrofes*) lesions. In these latter cases not only the clinical features but also the histopathology, bacteriology and immunology present peculiar characteristics which suggest this mutation of type, as can be seen in the definition of the lesions.

The Committee recommends the use of the term "neuritic" for the manifestations of the neurologic syndrome in preference to the old "neural" (*nervioso*), and also that of "leprid" for the lesions of benign type within the general concept of the cutaneous "microbids," that is, lesions actually uninhabited.

#### PROPOSED CLASSIFICATION

##### Clinical forms:

- I. Lepromatous (L) type:
  1. Macular
  2. Diffuse
  3. Tuberculo-nodular
  4. Neuritic
  5. Systematic
- II. Indeterminate (I) group:
  1. Macular
  2. Neuritic
  3. Maculo-neuritic
- III. Tuberculoid (T) type:
  1. Macular
  2. Circinate (*figurada*)
  3. Neuritic
  4. Reactional

#### DEFINITION OF TERMS

##### I. *Lepromatous (L) Type:*

1. *Macular form.*—The eruptions of this form are designated *lepromatous macules*, and they may be hypochromic, erythematous, pigmented, or erythematopigmented.

The *hypochromic* macules have diffuse outlines, and may be slightly infiltrated. The *erythematous* macules are of pinkish tone, reddish or violet-red. There are other alterations of color tone: yellowish, brownish, coppery, or rusty, which may start as maculopigmented lesions or may associate with the congestive element and lead to the beginning of the process as mixed macules: *erythematopigmented* macules. Any one of these varieties may predominate in some cases, whereas in others macules of diverse varieties may be present simultaneously. The macules may assume a uniform aspect and possess an irregular and diffuse border. The central part of the lesion may appear normal or hypochromic, clearly differentiated from the erythematous or pigmented part which surrounds it. Eventually the lepromatous macules may assume an ichthyosiform aspect.

2. *Diffuse form.*—Discrete or generalized infiltration, at times marked; shiny aspects of the skin, generally more distinct on the face, backs of the hands, elbows and knees. Tendency to diffuse hypochromia. If there are typical efflorescences, then the case is defined as diffuse with such and such efflorescence.

4. *Tuberculo-nodular form*.—The efflorescences of this form are designated lepromatous or tubercles.

*Tubercles* are circumscribed lesions of dermal origin, which may or may not form elevations; firm to the touch; in color reddish, brownish, or bronzy; of variable size, miliary, pisiform, lenticular and at times larger. They may be isolated, confluent, or confused due to coalescence, constituting masses of more or less large dimensions and at times of mammilate aspect. The tubercles, as well as the other infiltrative lesions, may involve, besides the skin, the semimucosae and the visible mucosae, assuming in them aspects similar to those observed in the skin. The tubercles may ulcerate, producing tuberculo-ulcerous lesions.

*Nodules* are hypodermic lesions, firm to the touch; with or without external elevation; of spherical form; variable in size from that of a small pea in some cases to much larger in others. In those cases in which, in their evolution, the nodules adhere to the dermis, they usually give to the skin a pinkish or violaceous color and the so-called orange-peel aspect.

4. *Neuritic form*.—Areas of anesthetics, with or without enlargement of the peripheral nerves and characteristic manifestations.

#### II. *Indeterminate (I) Group:*

1. *Macular form*.—The efflorescences of this form are designated "macular leprids." Macules characterized by the presence, singly or combined, of achromia, hypochromia, or erythema, with anesthesia. In certain cases there may be distinct infiltration.

2. *Neuritic form*.—Areas of anesthesia with or without thickening of the peripheral nerves, generally with negative bacilloscopy, and generally accompanied by more or less marked neurotrophic deformities.

3. *Maculoneuritic form*.—Cases characterized by the combination of macular leprids and neuritic manifestations.

#### III. *Tuberculoid (T) Type:*

1. *Macular form*.—The efflorescences of this form are designated "macular leprids." Erythematous macules with anesthesia in which achromia and erythema are combined in variable degrees are ordinarily distinguished from the indeterminate leprids by the presence of a distinct outline and margins which may present moderate peripheral infiltration and at times fine pityriasis desquamata.

2. *Circinate form*.—Lesions (*figurada*) characterized by borders formed by the confluence of papuloid elements, which may or may not be covered by fine desquamata. This border, of brownish-erythematous or reddish color, or of other combinations of shades, surrounds a central area which is slightly atrophic, hypochromic, or of normal appearance; of centrifugal evolution and of variable shape, regular or irregular.

3. *Neuritic form*.—Cases characterized by the presence of areas of anesthesia and/or enlargement of the nerve trunks, and trophic manifestations characteristic of the neuritic process. Areas of anesthesia are generally accompanied by thickening of the afferent subcutaneous nerve branches, and, on the surface, by the accentuation of the follicular orifices, assuming at times an ichthyoid aspect. Nodular thickenings of the nerve trunks, subject at times to colliquative alterations.

#### IV. Reactional Subtype:

To this group belong cases which correspond to the characteristics proper to the tuberculoid type, and others of borderline nature which, in various features, at times resemble the lepromatous type.

These cases are characterized by the following: (a) The mode of origin: they appear in apparently healthy individuals or, more frequently, in cases of the indeterminate form; exceptionally, they appear in those of the tuberculoid type. The borderline cases frequently result from repeated (*subintraentes*) reactional outbreaks. (b) The type of eruption: reactional lesions in mass, tumified and succulent, numular, in plaques, erythrodermic; in children, nodular lesions. (c) The coloration and the border: brownish-red, ochre-red or brick-color, in certain cases scarlet-red; the outside border distinct and the inside one shading off. The reverse is seen in the borderline cases, which then acquire a rusty sepia color. (d) The general phenomena: ordinary lacking, but there may be, especially in the borderline cases, a septic state (fever, arthralgias, adenopathias, headache, asthenia, articular edema, acute neuritis, etc.). (e) Duration and regression: subacute course, with desquamation; regression complete only after some months, almost always involuting with vernicular scarring. The borderline cases leave no scars, but erythema and/or pigmentation. (f) Bacilloscopy: frequently positive in the skin and rarely positive in the nasal mucosa. The bacilli disappear relatively rapidly except in the borderline cases. (g) The reaction to lepromin: frequently negative in the course of reactional outbreaks, increase of positivity later on, coinciding with the disappearance of bacilli. The borderline cases are always lepromin negative and remain so. (h) The evolution: habitually benign, with a tendency to clinical healing; there may, however, be transformation to the lepromatous type, this most frequently in the borderline cases.

*Recommendation.*—The presentation in the scientific sessions of various papers on the borderline cases indicates the existence of a more or less established consensus concerning the clinical, bacteriological, structural, immunological and evolutive differences of these cases. For this reason it may be suggested that a more thorough study of them should be made so that, at the Sixth International Leprosy Congress to be held in Madrid, it may be decided with greater certainty whether or not it is necessary to create a transitional (T.T.) group.

#### REPORT OF THE COMMITTEE ON LEPRO REACTION<sup>1</sup>

By "lepra reaction" is understood the acute manifestations of the disease which occur during its chronic course, or which may appear at the onset as a manifestation of a previously inapparent or latent process.

This Committee, in synthetizing in this report the principal concepts regarding the pathogenesis, therapy and prognosis of lepra reaction, has taken into consideration the papers on this subject submitted to the Conference, the points of view brought out in the discussion of those papers,

<sup>1</sup> *Presidente*, Dr. Luis M. Bechelli (Brazil); *relator*, Dr. S. Schujman (Argentina); *miembros*, Drs. Moacyr de Souza Lima, Candido de Oliveira e Silva, Gomez Ortiz, J. Convit, L. España, V. P. Etcheverry and Temporini; *supentes*, Drs. Wilkinson, Fuertes, Brusco and A. C. Pereyra, Jr.

and the opinions emerging from the exchange of views on the matter among the members of the Committee.

*Pathogenesis.*—The Committee holds that as yet there has not been a conclusive study which permits the complete classification of this moot and complex subject. Taking into account the views which have been presented in this Conference on the adaptation syndrome in relation to lepra reaction, it is evident that these studies should be continued and intensified, as well as those related to the humoral reactions (hemoagglutinins, hemolysins, globulins), the physico-chemical reactions of the blood, and the bacteriology, in order to contribute to a better knowledge of the pathogenesis of lepra reaction.

*Therapy.*—Before going into the treatment of lepra reaction, the Committee believes it desirable to call attention to the following facts:

(a) That there are factors which by themselves may induce and govern the reaction, in order that measures may be taken to modify or suppress them if possible.

(b) That as yet there exists no treatment which will give satisfactory, lasting and uniform results in the majority of cases of lepra reaction.

(c) That there is a proportion of reactions that will retrogress spontaneously; and that not all respond to the same treatment, nor are there always obtained the same beneficial effects with a given medicament; thus the variety of medicaments used: desensitizing drugs, antihistaminics, antimony derivatives, and recently cortisone and ACTH.

With regard to therapeutic management to be followed in the different types of reaction, the following should be taken into account:

In the *tuberculoid reaction*, in which the general condition is always good, the treatment of the leprosy infection should be continued at the same time that measures are taken against the symptoms of the acute manifestations, especially those which by their location (trunk neuritis) may entail serious ultimate consequences.

In the stages of the *borderline reaction*, together with the medication against the acute symptoms, the dose of the antileprosy medicament is to be continued and, if the patient's condition permits, it should be increased.

The type of treatment to be employed in the *classical lepra reaction of lepromatous leprosy* depends upon the intensity of this reaction. When it is slight, one should not be preoccupied with the phenomena of acute manifestations, and the usual treatment of the leprosy infection should be continued. When it is severe and intense to the degree of disturbing the patient, his family, and even the physician because of later consequences, attention should be concentrated on combating the acute syndrome of the reaction. The above-mentioned desensitizing medications should be used, and if the response to them is inadequate one should resort to cortisone and ACTH, especially when the reaction is accompanied by intense neuritis, arthralgias and acute ocular manifestations.

*Prognosis.*—As an element of prognosis we should take into account the *ad vitam* factor, the evolution of the reaction itself and the influences that it may exert upon the later course of the disease.

In neither tuberculoid leprosy nor the borderline condition has there been observed as yet a fatal termination that could be attributed exclusively to the reaction.



The prognosis of the former is the better, because it frequently regresses due to its much shorter duration and to its lesser tendency to relapse. This prognosis may be more serious when the reaction is localized in the nerve trunks, because of the sequelae that may ensue.

More serious, on the other hand, is the prognosis of the borderline reaction, especially in comparison with the one just mentioned, because it is of much more prolonged duration, because the lesions are bacteriologically positive for long periods, because of the greater tendency to relapse, and especially because it may sometimes change to the lepromatous type. When, however, the borderline condition arises in the lepromatous form, the prognosis is better because it is an indication of favorable later evolution of the disease.

It is in the classical reaction of the lepromatous form (erythema nodosum and multiforme), especially in the severe ones, that exceptional cases of fatal endings have been recorded; it is in these severe cases that the use of cortisone and ACTH is recommended.

*Influence of lepra reaction in the later evolution of the disease.*—From an analysis of the papers on this subject presented at the Conference, the Committee concludes that lepra reactions, especially if they are intense and persistent, seem to exert a favorable influence on the later evolution of lepromatous cases; but it considers that this view should be supported by more ample observations in the various centers of leprology of the world. For this it recommends that in the progress records of lepromatous cases, similar in their severity and the type of treatment, the reaction conditions should be recorded and the later evolution of cases which have had no reactions should be studied comparatively with those that have had them frequently and intensely.

With respect to the value of provoked lepra reaction, considering the short experience and the limited number of cases which have been dealt with by only a few authors, it is to be hoped that more extensive observations on a greater number of cases may come from these same authors in order that conclusions may be reached on this matter.

## REPORT OF THE COMMITTEE ON THE REVERSIBILITY OF THE CLINICAL FORM OF LEPROSY AND OF THE REACTION TO LEPROMIN<sup>1</sup>

### 1. REVERSIBILITY OF THE CLINICAL FORMS

The Committee admits as an undeniable fact the phenomena of mutation and of reversibility of the clinical forms. In this reversibility two aspects are distinguished:

(a) Reversibility of the structure of the polar types to the "simple or nonspecific chronic inflammatory."

(b) Clinical reversibility of the polar types. It is admitted, however, that from this point of view two distinct phenomena may occur: One, of true regression to the previous indeterminate stage, from which, in the case of tuberculoid regression, it may change to the other polar form.

<sup>1</sup> *Presidente*, Dr. Lauro de Souza Lima (Brazil); *relator*, Dr. Hector Fiol (Argentina); *miembros*, Drs. Herrera, Lygia de Andrade, Rosas, Olmos Castro and Quiroga; *supentes*: Drs. Guadagnini and Jonquieres.

The other, different in prognostic significance, is the involution of the polar types that are in the process of healing, first passing through the stage of residual lesions; and so far as possible such cases should be distinguished if there has been opportunity to follow their evolution.

Admitting this diversity of phenomenon, it is recognized however that, for purposes of classification, it is sometimes impossible to separate the two conditions in those cases which are seen for the first time presenting the indeterminate aspect, and whose previous evolution cannot be ascertained.

## 2. REVERSIBILITY OF THE REACTIONS TO LEPROMIN

The Committee prefers to use the term "variability" (*viraje*) instead of "reversibility," to indicate the changes of the immunological phenomenon revealed by the Mitsuda reaction.

In leprosy patients this variability has been observed to occur spontaneously, although exceptionally, from positive to negative.

Under various conditions (administration of sulfones, BCG, etc.), on repetition of the Mitsuda test it has been observed to become positive after having previously been negative or doubtful.

This variability has been found in lepromatous leprosy, in a very small percentage of cases, although the positive reactions have been weak.

The same phenomena of change to positivity of the lepromin reaction have been seen in healthy persons, occurring either spontaneously, or provoked by sulfones, by BCG, or by repetition of the Mitsuda test.

According to the reports presented to this Conference, BCG seems to have provided the highest percentage of this change to positivity. On the basis of these results, the Committee recommends the general application of BCG to determine definitely its value in leprosy.

## CLINICAL EVALUATION STUDIES OF THE LEONARD WOOD MEMORIAL

After having secured from various sources the necessary funds for the project, Dr. James A. Doull, medical director of the Leonard Wood Memorial, accompanied by Dr. Lucius F. Badger, of the U.S.P.H.S., made a round-the-world trip between September 24th and December 22nd, 1951, to complete arrangements for the establishment of three centers at Pretoria, in South Africa, at Cebu, in the Philippines, and at two institutions in Japan for controlled studies of antileprosy drugs. The institutions and personnel concerned are as follows:

Westfort Institution, Pretoria (director, Dr. A. R. Davison); research leprologist, Dr. A. R. Davison (acting); consultant, Dr. J. Marshall, Johannesburg.

Eversley Childs Sanitarium, Cebu (director, Dr. A. F. Runez); research leprologist, Dr. J. G. Tolentino; consultant, Dr. J. N. Rodriguez, Manila.

Aisei-en and Komyo-en National Leprosarium, both on Nagashima Island in the Inland Sea, Japan (directors, respectively, Dr. Kensuke Mitsuda and Dr. Ryoichi Jingu); research leprologists, Dr. T. Miyata, at

Aisei-en and Dr. M. Namba, at Komyo-en; consultants, Dr. Y. Hayashi, Tokyo, and Dr. T. Nojima, Oshima.

The funds for this project were obtained largely by a grant from the Public Health Service, while several pharmaceutical companies participated with donations of funds and/or of drugs. Much of the cost of the transportation of the trip of Drs. Doull and Badger was donated by the Pan American Airlines, and steamship companies have transported drugs and other supplies and equipment without charge. The articles shipped to the centers, including such things as special cameras, photographic supplies, chemicals and apparatus, are not listed in the report from which this note is largely taken (*Leprosy Briefs*, January, 1952), but it is mentioned that the drugs sent out include 48,600 gm. of dihydrostreptomycin, 246,000 tablets of sulfones, and 1,244,000 tablets of *p*-aminosalicylate. In all three of the countries arrangements were made for admission of supplies and equipment without the formality of import licenses. The Japanese government has made a cash grant for the project equivalent to one-half of the anticipated expenditure of the Memorial in Japan in 1952.

The numbers of patients involved in the study are: at Westfort, 240; at Cebu, 360; and in the two Japanese institutions, 360. Only patients classified as of the lepromatous type, with negative or doubtful lepromin reactions, are being used. At each of the centers the patients were to be divided into six groups in random manner, and the several groups were to receive the same treatment at all institutions. Each was to be approximately similar with respect to age and sex, and to the proportion of patients previously treated with sulfones.

To ensure understanding and agreement on all phases, there was prepared a Manual for Collaborating Investigators, which contains detailed instructions for various examinations, physical and laboratory; dosages and methods of administration of drugs; photography; record keeping, and reporting to the medical director of the Memorial. During the preliminary examination period the patients were on rest from treatment, after which the experimental therapy was to be continued for 32 weeks. A detailed mid-period examination is provided for and a final complete reexamination. On these three examinations the consultants are required to check the findings of the research leprologists who are in immediate charge of the treatment, without being informed regarding the therapy group to which individual patients belong.

At each center at least one-third of the patients are to be biopsied. One-half of each specimen is to be examined locally and the other half at the Armed Forces Institute of Pathology in Washington, D. C., where the Memorial is sponsoring the Leprosy Registry.

These studies are the first series of a projected continued program. No new drugs are being used in this series, the objective being to "place certain widely used drugs in their proper perspective." In future series new drugs which show promise will be studied.

## THE LEPROSY SERVICE OF ARGENTINA

From preparatory Bulletin No. 3 of the Third Pan-American Leprosy Conference is taken the following list of institutions and senior medical personnel of the Argentine leprosy service, the *Dirección de Dermatología* of the *Ministerio de Salud Pública*.

Dr. Leonidas Llano is the director, Dr. Ernesto T. Capurro is the technical secretary (vice Dr. Carlos F. Guillot, transferred to another department), Sr. Armando Sangregorio is chief of the Section of Preventoria and Social Welfare, and Sr. Raúl H. Ceballos Reyes is "asesor técnico." Of the several leprosaria of the service, Dr. Hector Fiol is the director of the Sanatorio "Baldomero Sommer," Dr. Mario A. Guadagnini is the subdirector, and Drs. Carlos M. Brusco and Enrique D. L. Jonquieres are also members of the staff. The directors of other leprosaria are: Dr. Miguel Baldino, at the Sanatorio "M. Aberastury," in Corrientes; Dr. Antonio Reviriego, at the Sanatorio "Enrique Fidanza" at Diamante, Entre Ríos; Dr. Arturo Temporini at the Sanatorio "José J. Puente," at San Francisco del Chañar, Córdoba; and Dr. Héctor H. Orlando is director of the Sanatorio Dermatológico (Lepra) in La Plata. Dr. Luis Argüello Pitt is director of the *Dispensario Dermatológico* (Lepra) of Córdoba, Dr. Norberto Olmos Castro is chief of a similar dispensary in Tucumán, and Dr. Ricardo S. Castro of one at Concordia; the latter two, at least, are under the service.

It would appear that there is—or has been—an official *Campaña Nacional Antileprosa*, previously headed by Dr. Marcial L. Quiroga, professor of dermatology and syphilology at the University of Buenos Aires; at any rate there are "delegates" of the M.S.R. *Campaña Antileprosa* at Rosario (Dr. Juan B. Serra) and in Córdoba (Dr. Enrique Tello). Dr. Guillermo Basombrio is director of the *Centro de Leprología* of the University of Buenos Aires, independent of the service.

Under the *Patronato de Leprosos*, of which Sra. Hersilia Casares de Blaquier is president, Dr. Virgilio Etcheverry is chief of the leprosy dispensary of the *Muñiz Hospital* in Buenos Aires and director of the preventorium "Mi Esperanza." The *Patronato* also supports an antileprosy dispensary in Corrientes, of which Dr. Manuel H. Iglesias is director. At Rosario, supported by the local *Patronato*, is another "Mi Esperanza" preventorium of which Dr. José M. M. Fernandez is director. At that place the municipal Carrasco Hospital has a leprosy service, of which Dr. Salomón Schujman is the chief.

## VILLAGE CLINICS IN EASTERN SIAM

During the past year a system of village clinics has been started at Khonkaen, located northeast of Bangkok and about 100 miles from the Indo-China border, according to information received from Miss Bette Johns, R.N., of the Christian and Missionary Alliance. There is a large leprosy problem in this region, and the government has a colony near the city where about 250 patients live; they receive a food and clothing allowance, and chaulmoogra oil if they wish to inject themselves.

This colony offered little prospect for the development of

active work among the patients, so a beginning was made by establishing a clinic in a Christian cemetery near a small village which patients from the colony had built for themselves on common land. Fourteen patients attended the clinic on the first day in July 1951, but on the second clinic day 114 presented themselves, and the number has continued to increase. The clinic was moved to a thatched building which the patients built themselves in their village. Later four other centers were opened in other similar villages of leprous persons, and in this way 1,612 have now come under treatment.

This system works well among these people, for the clan spirit is strong and the affected people usually live in their home villages, often near to but sometimes apart from the unaffected people. Here they own land and property and this simplifies the matters greatly.

The medical aspect of this work has been carried on by Miss Johns single-handed within recent months, but assistance is expected shortly, and it is hoped that the mission will appoint a doctor to help with the task of organization and supervision. Dr. Buker, of Chieng Mai, has been behind this development as adviser and teacher, and he is an enthusiastic advocate of this village clinic type of work.

—NEIL D. FRASER

## NEWS ITEMS

6 **United States: Pacific Tropical Diseases Research Project.**—This recently-established project, whose headquarters are in the Department of Infectious Diseases of the University of California School of Medicine at Los Angeles—of which Dr. Charles M. Carpenter is the head—and whose director is Dr. John F. Kessel, has for its immediate objectives the continuation of the study of filariasis in French Oceania, a study of the recent outbreak of poliomyelitis in Tahiti, and the study of other tropical diseases such as leprosy and yaws. The long-range objectives are to provide a center for teaching and research on tropical diseases on the Los Angeles campus and continuation of field studies in the Pacific Ocean area. The work will be done in cooperation with the U. S. Public Health Service and the French Colonial Medical Service. Early this year Dr. Kessel was in Tahiti, organizing the field staff.

7 **Leonard Wood Memorial announcement.**—It is announced by the Leonard Wood Memorial that the name of its Department of Information has been changed to Department of Public Relations. The department remains under the direction of Mrs. Perry Burgess (Cora Turney Burgess). Mr. Arthur Taylor has succeeded James Brown as technical assistant for the Memorial's Section of Photography under the Department of Public Relations.

8 **The A.M.A. and "Hansen's disease."**—It is reported that the latest edition of "Standard Nomenclature" of the American Medical Association, published under the editorship of Dr. Richard J. Plunkett, recognizes "Hansen's disease" as the official synonym for the term "leprosy."

9 **The word "leper" prohibited.**—Dr. Frank C. Combes, of New York, is reported as having stated at a meeting of the American Dermatological Association last year that "it is a federal offense to call a person a leper," and that one could be prosecuted for doing so by the federal government. [The basis for this statement is not known to us.]

10 **Leprosy increasing in New York.**—Under this heading newspapers have reported the gist of a paper read by Drs. Orlando Canizares and Frank C. Combes before the last annual meeting of the Medical Society of the State of New York. Statistics are not available because the disease is not reportable, but 32 cases were reported in New York City in January and it was believed that there were at least three times as many either unreported or not diagnosed. Many cases are imported, but "we must assume that [the disease] may be contracted in this state, too." Among other things, the writers recommended that leprosy should be made reportable, that patients should be required to report to physicians for medical treatment, and that a distinction should be made between open and closed cases. [No indication of what the distinction should be appears in the reports seen. No report of an indigenous case arising in New York is known to us.]

11 **Thirty years at Carville.**—A story in the New Orleans *Times Picayune*, by Stanley Stein, of Carville, tells of three men who have now been there for thirty years. They were among 33 patients who had been transferred there from San Francisco shortly after the federal government took over at Carville. Their birthplaces were Mexico, Greece and China. One of them, 76 years of age, has spent 62 years in isolation.

6 **Norway: Number of cases.**—Dr. R. Melsom reports that at the end of 1951 there were 11 patients in the leprosy hospital at Bergen, Pleistiftelsen, No. 1, and 1 other patient living at his home in the country, making a total of 12 cases. Of the hospitalized patients, 5 are males and 6 are females; 1 is a nodular case, 7 are maculoanesthetic, and 3 are mixed. During the year 2 new cases, siblings, were registered, although one of them had been reported in 1950. One of the old patients had died.

6 **Ethiopia: WHO leprosy consultant.**—In December 1950 and January 1951 Dr. M. A. K. Dalgamouni, director of the Leprosy Control Section of the Ministry of Health of Egypt, visited Ethiopia as a short-term WHO consultant to introduce sulfone treatment in the leprosy institutions there. The government hospital, at Akaki, near Addis Ababa, established in 1932 with the aid of the (then) American Mission to Lepers, had some 340 leprosy patients, with a physician on half-time service and a former patient serving as administrator. At Herrar the old Capuchin leprosarium, operated by French missionaries, had about 250 patients, with a resident physician. In total, 230 kgm. of sulphetrone was left, enough for the treatment of 700 patients for a year. Among 1,500 secondary school children examined at Addis Ababa, 1 definite case (tuberculoid) was found, and about 15 suspects with hypopigmented patches but apparently normal sensation. The establishment of a leprosy clinic in that city was recommended, partly to obtain data for statistical purposes, which as yet are completely lacking, and partly because many leprosy patients, as well as others, are being treated by "medicine men" with secret remedies. In the tropical lowlands the American Leprosy Missions, Inc., is establishing a leprosarium at Chachamenni, and one is being constructed at Chachamenni by the Sudan Interior Mission. [In part from *Leprosy Briefs*, issue for November 1951.]

6 **Leprosy adviser provided.**—Dr. Mustafa Kamel, director of the Amriya Leprosy Colony, near Alexandria, Egypt, has been appointed by WHO to undertake a one-year assignment as leprosy adviser to the Government of Ethiopia, according to the *WHO Chronicle*. Dr. Kamel will follow up the antileprosy work begun last year by Dr. M. A. K. Dalgamouni. Dr. Kamel has studied leprosy control in the Philippines and India as well as in Egypt, where he has held a number of posts: inspector of the Leprosy Section of the Egyptian Ministry of Health, chief medical officer of the same Section, and director of the Abu-Zaabal Leper Colony, near Cairo.

6 **Philippines: Philippine Leprosy Society organized.**—At the annual convention of the Philippine Medical Association for 1952, a group of individuals who had been previously communicated with in the matter by a committee appointed by the Culion Medical Society met to complete the organization of the Philippine Leprosy Society. Because of the limited number of members present, it was decided that the permanent officers for 1952-1953 should be elected by postal vote. Application therefor having previously been made, the House of Delegates of the Philippine Medical Association approved the creation of a Section on Leprology and the affiliation of the new specialty society. Affiliation with the International Leprosy Association is to be sought.

6 **WHO: Expert Committee meeting.**—Plans are being developed for convening the first meeting of the Expert Leprosy Committee, to be held

this fall. No general announcement has been made of its composition or agenda, which at the time of writing has not been completed. According to available information the meeting is to be held in Geneva, Switzerland, in late September.

#### PERSONALS

DR. HARRY L. ARNOLD, JR., has been elected president of the Hawaiian Academy of Science.

DR. FRANCIS G. BLAKE, civilian director of U. S. Army medical research on leave from his position as chairman of the Department of Internal Medicine of Yale University School of Medicine, and a member of the Advisory Medical Board of the Leonard Wood Memorial, died on February 1, 1952.

DR. W. M. BONNE, acting director of the Division of Communicable Disease Service of WHO, has recently visited certain other Far Eastern countries after attending the treponematoses conference in Bangkok. While in Indonesia and the Philippines—the latter of which he visited for other purposes—he took advantage of the opportunity to discuss leprosy problems and plans with workers in that disease.

DR. EDWIN K. CHUNG-HOON, of Honolulu, has been chosen president-elect of the Hawaii Territorial Medical Association.

DR. ROBERT G. COCHRANE, medical secretary of the British Empire Leprosy Relief Association, has made a brief tour visiting India, Ceylon and Malaya, in January and February. The purpose of the trip was to investigate research possibilities in those countries. In March he left England for a tour of West Africa.

DR. JOHN FRANCIS, who as a member of the staff of the biological laboratories of Imperial Chemical (Pharmaceuticals) Limited, in Manchester, England, pioneered in the use of DDS in cattle disease and influenced its trial in human leprosy, has accepted appointment as professor of preventive medicine in the University of Queensland and School of Veterinary Science, Brisbane, Australia.

DR. JOAQUIM MOTTA, born in Rio de Janeiro on December 19, 1894, died suddenly of heart trouble on January 26, 1952. He was assistant of the former Inspectoria de Prophylaxia da Lepra (1921-1930) and later director of the Serviço de Lepra, Federal District. He was also professor of dermatology, Faculdade de Ciências Médicas, of Rio de Janeiro City.

DR. H. C. DE SOUZA-ARAUJO informed us in February that he was shortly to return to Buenos Aires, where he had attended the leprosy conference in December, to study his cultures by electron microscopy with Dr. M. G. Malfatti, and that similar work was to be done with Dr. Hans Muth on the leprosy bacillus and other pathogenic mycobacteria. DR. MALFATTI, on invitation of the Brazilian government, was in that country in April and May giving conferences on investigations with the electron microscope.

DR. ERNEST LINWOOD WALKER, of the University of California (retired, professor emeritus, in 1940), long interested in the bacteriology of leprosy, died in January of this year.



### WILLIAM LLOYD AYCOCK

W. Lloyd Aycock, an outstanding epidemiologist, died in Boston on October 24, 1951, at the age of 63, following an operation for the relief of pressure on his cervical spinal cord. He had been engaged in epidemiologic research and teaching at Harvard since 1923, and had been associate professor of preventive medicine and hygiene there since 1941.

Chiefly known for his vitally important contributions to our knowledge of poliomyelitis, which numbered over 80 papers in thirty-one years, he also contributed importantly to the literature on leprosy. In 1938 he first published with Earle B. McKinley, an account of the applicability of the principle of familial susceptibility, which he had enunciated in connection with poliomyelitis, to the epidemiology of leprosy. In 1940 and 1941 he published three more papers on this subject, and in 1948 proposed a study with reference to the relative roles of contagion and heredity in the causation of leprosy. At the time of his death he was working in cooperation with the Hawaii Territorial Department of Health on a paper dealing with racial and familial susceptibility to leprosy in Hawaii.

Born in Georgia, Lloyd Aycock was a Yankee by adoption, and he had a Yankee's proverbial penetrating common sense. "They're tryin' to find out more about polio," he once remarked, "than we know about *disease!* Is measles virus present in the feces?" And again, "They think that because we don't know how leprosy spreads, it must not be very contagious. Ask 'em how measles is spread." This is reminiscent of the Connecticut Yankees' request of the magician who offered to tell him what anybody in the world was doing at that moment. Putting his right hand behind him, the Yankee said, "Tell me what I'm doing with my right hand." Of the higher incidence of leprosy in young persons, Dr. Aycock once remarked, "That's true of most contagious diseases, isn't it?"

Dr. Aycock was a genial, warm, friendly person, who prized few things more than a couple of hours' conversation, a pastime at which he excelled. His quick repartee and inexhaustible store of illustrative anecdotes and reminiscences made talking with him the pleasantest and most stimulating of experiences.

In closing, I cannot improve upon the final paragraph of

Dr. Aycock's obituary notice in the *New England Journal of Medicine* for January 24, 1952, which reads as follows:

"Lloyd Aycock was so busy working and writing and talking and reading that he never had much time to dwell on the infirmity of his later years, so nothing need be said of it here. He conquered it with simple homespun courage, a capacity to laugh at himself and a contagious friendliness that will long be remembered."

—H. L. ARNOLD, JR.