of injections given, cases of tetanus were exceptionally rare. It is undoubtedly possible to organise mass treatment on a basis of administration by injection. Nevertheless, after several years experience with DDS given orally on a very large scale through the medium of local leprosy control workers, it can be stated that the oral method has everything to commend it in the circumstances prevailing in Nigeria. Our experience is that by and large patients do get their treatment everywhere, and any wastage or irregularity that goes on is on so small a scale in relation to the total effort as to support no reasonable criticism of the methods adopted.

At all local centres detailed records of all treatment are kept, and checked against DDS supplies to that centre from time to time by responsible persons. Dosage of DDS is standardised on a basis of twice weekly or weekly treatment, with a maximum dose of 400 mg, twice weekly or 600 mg, weekly. The patient is given his treatment in the presence of witnesses, and takes it then and there. He is not given any to take home. Apart from the regular visits of the doctor, any local centre is liable to be visited without warning by the doctor or his deputy and all its activities reviewed, while the work of the local worker (or Leprosy Inspector as he is called), is gone into in detail. By such methods reasonable control of both treatment and other activities can be maintained, and their success is evidenced by the thousands of patients now discharged symptom free, the rapidly growing proportion of patients now attending in the very early stages of the disease, and the fact that survey after survey demonstrates that only a small minority of patients fail to attend their local clinic, once this is firmly established and its purpose understood by the people. One cannot speak too highly of the work of Leprosy Inspectors as a group in leading to such results.

Nigeria Leprosy Service Research Unit, Uzuakoli, E. Nigeria.

T. F. Davey
matter was therefore carefully studied at the outset in the five clinics around Kaduna based on Local Authority Dispensaries, and also other questions involved in the successful operation of such clinics with a minimum of supervision once they should be put on a sound basis.

The dosage schedule evolved for general routine starts tuberculoid and mild lepromatous cases on one 100-mgm. tablet a week, to be slowly increased to four, and then—but only by order of the supervising medical staff—increased to six. The severe lepromatous cases commence with one-half a tablet a week, and they are slowly increased by one-half tablet to 2; then, if no reaction is seen, the dose is again slowly advanced to 3 and 4 tablets. The maximum dose for lepromatous cases is 4 until signs of healing allow a dosage of 5, and again after a considerable period 6 tablets. These larger doses for lepromatous cases were established when it was found that, after some 15 months of treatment, the majority of such cases, even severe ones, tolerate larger and more effective doses, and that after 2 years they could be treated on the same scale as tuberculoid cases.

Ministry of Health
Kaduna, Northern Nigeria
C. M. Ross
Senior Specialist (Leprologist)

ORAL DDS TREATMENT BY THE GANDHI FOUNDATION

To The Editor:
This is a brief summary of experience with the use of DDS by mouth in the ten rural clinics of this Foundation which have gradually been established since 1952 for the control of the disease by this means. At present we have under this treatment about 4,300 patients from the control area proper, and nearly 6,000 from outside the area, totalling about 10,000.

As the patients have to take the drug daily, for six days of the week, when they come to the clinics they are given quotas for one or more weeks, depending on circumstances. They take the medicine home and consume it there. At the outset they are told about the signs of intolerance, and are asked to stop the drug and report to the medical officer in case they have trouble.

The starting dose is low. In lepromatous cases it is usually 10 mgm. daily, but in very advanced cases the starting dose is smaller or the patients are instructed to take the 10 mgm. dose less frequently, as three times a week. If tolerance is good the dose is increased weekly until the 100 mgm. daily dose is reached. In nonlepromatous cases the initial dose is usually 25 mgm. daily, increased weekly to the same maximum.

The once-a-week rest day is usually sufficient, for the majority of the patients are a little irregular in attendance and they get rest periods from that. Those who are very regular are usually given a fortnight’s rest after six months, but there is no hard and fast rule in this matter.

Intolerance has not been frequent. It is seen in a few lepromatous cases, but not more than 1 per cent of them; also, an occasional tuberculoid case cannot take the drug. A few cases after a time develop a mild degree of anemia, but they respond well to iron, B12, or liver extract. So far we have had no case of the jaundice, or psychosis, or severe dermatitis described by some other workers. After some months, in a few cases, reactions suddenly develop, but reactions are seen without any treatment and there is no reason to believe that the drug is particularly responsible for these events.

As for the results of this treatment, our attention has been focused on other data and I can give only my general impressions. Most cases with early nonlepromatous lesions clear up completely in from 3 months to 1½ years. Tuberculoid cases, with few exceptions, respond very well and the lesions disappear in from 6 months to 2 years; a few show good progress for some time and then become...