DDS TREATMENT IN NORTHERN NIGERIA

TO THE EDITOR:

When in 1951 I came to the Northern Region of Nigeria to organize an anti-leprosy campaign it was evident that it would be impossible here, where farm land is scarce and the outlook of the people is different from that of the peoples in the southern regions, to establish—at least at the outset—voluntary segregation villages such as are an important part of the system in the south. The existing leprosaria, or "settlements," valuable as is the work they do, could not much more than touch the fringes of the enormous problem.

That problem could only be attacked by a system of outpatient dispensaries, which seemed promising because, although the people know leprosy well but have no great fear of it and do not ostracise its victims, they greatly desire to be rid of it. Furthermore, the clinics would have to be very simple; and for the most part they are, as is evident from a report which Mr. S. M. Keeny, of UNICEF, made after a short visit here last year. [See the news section of this issue.] Consequently, the treatment—by DDS, which UNICEF is now supplying—would have to be by mouth; no other method would be possible. The injection method could not be used because, for one thing, the people here—unlike those in some places—do not like injections and would not come forward as willingly as they do for the oral treatment, and an injection program would require more skilled personnel than is available. Satisfactory results have been and are being obtained by the oral treatment with DDS.

The problem of dosage was one of primary importance, for when visiting the inpatient settlements here I had been impressed by the frequency of lepra reaction and fever in lepromatous cases. The scheme of dosage in common use was obviously unsatisfactory for use in the clinics, which for the most part would have to be run, under only periodic supervision, by lay workers after short periods of training. This

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.

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