NEWS AND NOTES

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

XII INTERNATIONAL CONGRESS OF DERMATOLOGY

Some time ago Dr. Sven Hellerström, of Stockholm, requested that we run an announcement to the effect that the XIIth International Congress of Dermatology is to be held in Washington, D. C., September 9-15, 1962; also to note that the International League of Dermatological Societies is now in official relationship with the World Health Organization as a nongovernmental organization [THE JOURNAL **27** (1959) 393]. Dr. Hellerström is secretary-general of the International Committee of Dermatology (and of the League), and Dr. Marion B. Sulzberger, of New York, is president. Dr. Donald M. Pillsbury is to be president of the Washington congress, and Dr. E. D. Osborne its secretary.

These dermatology congresses are held every five years, the XIth one having been held in Stockholm in 1957. We have long been curious about how they are organized, and some of the data supplied by Dr. Hellerström at the time of his request led us to make inquiries of him, to which he kindly replied quite fully. He also supplied a reprint of the Rules and Regulations of the International League of Dermatological Societies (*Acta Derm-Ven.* **37** (1957) 419-431).

Ostensibly the League, which was not created until the last (Stockholm) congress, is an organization of national societies of dermatology, and its principal purpose is to hold international congresses. At a congress the affiliated national societies are represented by delegates to an Assembly of National Delegates, which elects members of the International Committee and selects its officers. The latter, only, provides for continuity between congresses.

Actually, the League was created as a cover to convert to a *de jure* body, with appropriate statutes, a *de facto* affiliation of national societies which had long supported the International Committee—to give the organization "exterior legitimization" as an international body. In actuality, if not by statute, its officers are those of the International Committee.

Previously there had been only the International Committee—and that had not been in existence for very long, since it was founded in 1930 at the VIIIth Congress in Copenhagen. It is related that, as far back as the VIIth congress held in Rome in 1912, an attempt was made to establish an international society—that one based on individual memberships—but that attempt proved abortive; it is said that the plan proved difficult to carry out, and then World War I interfered. There was no congress for eighteen years, until Copenhagen in 1930.

At that time it was planned that the International Committee should be composed of 11 to 15 members, who should be chosen (as explained later) on the basis of personal

qualities and experience with congress work, and not nationality. During the next 20 years or so, it may be suspected, the ICD was not particularly active, for at the time of the Xth congress, held in London in 1952, only 3 of the original 11 members were still alive and those who had passed away had not been replaced. The number was brought up to 12 at that time, and that number has been maintained since then. One-third of them are to be changed at each congress—the oldest of them—but reelection is not prohibited. The Committee is not exactly self-perpetuating, but it does nominate new members to be voted on by the Assembly. Four officials of the past and the up-coming congresses are also *ex officio* members of this committee.

For a congress, the national societies (not the governments) nominate delegates two years in advance, and at the meeting these delegates constitute the Assembly of National Delegates. The number of delegates allowed each national society depends on the number of its members (1 delegate if 20-100 members, and a maximum of 4 delegates if more than 500 members). Apart from the Assembly, a congress is open to "all dermatologists of the world," on payment of the congress fee. (This would provide for congress membership, but not for representation in the Assembly, of persons from countries without affiliated national societies.)

The Assembly of a congress, which is presided over by the president of the ICD (not of the congress itself), elects the members of that Committee and selects its officers, decides the site of the next congress and elects its president, makes rules and regulations for the organization of the international congress, appoints special committees if necessary, and fixes the amount of the subscription for the next period. Its authority does not extend beyond the congress at which it is assembled.

The International Committee, which carries the torch and is behind the work of the Assembly since it prepares its agenda, operates most of the time by correspondence, but it has one expense-paid meeting midway between congresses and meets again at the congress immediately before the meeting of the Assembly. Its stated functions are (rather vague) to deal with all questions regarding dermatologic problems of international importance, to represent the interests of international dermatology in relation to other organizations, and (more specific) to make suggestions regarding the organization of the next congress, to select subjects to be considered and to choose the opening speakers, and to prepare the agenda for the Assembly of National Delegates. To support it, each national dermatology society is supposed to pay a small fee (10 cents U. S. per member per year) in a lump sum every five years.

It appears that there is some difficulty in collecting the dues. In the Assembly of the XIth Congress, 41 nations were represented, but the societies of only 29 nations had made any payment during the preceding five years. Of them, three had no representatives—while on the other hand there were national delegates from no less than thirteen countries from which no payments had been received. After an extra ICD meeting held at Zurich in January 1956 (to which the travel expenses of only the Secretary-General and his assistant had been paid) the Committee had a balance of only about $2,000 in 1957.

There have been discussions in ICD meetings as to what function—if any—should be allowed delegates from societies that have not paid their dues. At Stockholm it was proposed that they should be accepted only as "observers." More recently the ICD has decided that societies which have not paid will have no right to send delegates "unless the Committee believes that they have shown good and sufficient reasons for demanding a delay in payment."

"The principal task of the Committee is to manage all questions connected with the international congresses," it was stated on one occasion, and its responsibilities under the statutes of the League are stated to be: To establish the scientific program of the next congress at its regular interim meeting, "insofar as it concerns the choice of subjects as well as that of the speakers." To facilitate matters it was decided to invite the president and secretary of the next congress to attend that meeting. In case a congress cannot be held at the stated time, the ICD consults with the local organizing committee in the setting of a new date. Beyond that, it is the president of the congress and his organizing committee who are responsible for the organization of the congress, and for the publication of a book of summaries before the meeting and its transactions afterward. The agenda of each session is drawn up by the secretary of the congress.

Before the Stockholm congress the ICD had agreed on a program of 7 main themes, 17 symposia and 2 committees, but as it ultimately worked out 1 of the themes and 2 of the symposia were dropped for lack of contributions. The ICD agreed that the Washington congress should be organized as follows: 3 days to be reserved for the principal topics (not less than six), the forenoons to be devoted to the statements of the official reporters, the afternoons to discussions of the reported subjects of the morning, with simultaneous translation in each of the lecture rooms; 1 day for symposia, 10 to 15 taking place at the same time; 1 day for case presentations; and 1 day free.

According to a decision of ICD, "free communications" would be accepted only if they pertained to subjects of the main themes or symposia.

The statutes provide that no report or communication that has been printed, or read before another learned society, may be presented *in the same form* to the congress. Also —a rule that would be difficult to enforce—that if any papers presented at the congress should appear elsewhere before the transactions appear, they may be represented only by summaries. It is also provided, among other things, that because of the high cost of printing the Editorial Board may call upon the author to curtail any communication to 1,500 words (inclusive of space for tables), no pictures being allowed. The high cost of simultaneous interpretation had limited them, for the Stockholm congress, to one location.

At that meeting Hellerström, reporting on his experience with the double-barrelled job of secretary general of the ICD and of president of the congress, said in part:

"The organizing period is a rather hectic time, though it does not make itself felt from the beginning. Gradually you find that those long five years of preparations which seemed more than adequate dwindle with an ever increasing rapidity, until suddenly . . . . you find yourself standing here addressing the meeting . . . and there is no time left for altering [any of the] details which I now know could have been arranged in a much better way. The trouble is that you ought to have organized one or perhaps two congresses until you know just how it should be carried out. Our main idea in organizing this congress was to make it differ in a better way from former congresses, to cut out a great number of free contributions and to group the interest around discussion groups of experts, debating special topics. Papers can be read in journals, perhaps with better profit

than listened to at a congress. But at congresses experts in a field come together and I am sure an opportunity to listen to their discussions should not be missed."—H. W. W.

SYMPOSIUM ON LEPROSY, SCHOOL OF TROPICAL MEDICINE, CALCUTTA

On January 30, 1961, the anniversary of Gandhi's death having been chosen for World Leprosy Day, a symposium was held at the Calcutta School of Tropical Medicine and is reported in the *Bulletin* of that school [**9** (1961) 69-92]. The presentations, which are mostly brief (or have been condensed), were, after a welcome by Dr. R. N. Chaudhuri, Director of the School, and an inaugural address by Lt-Gen. D. N. Chakravarti, Director of Health Services of West Bengal and chairman of the meeting, on the following topics:

CHATTERJEE, S. N. *Classification of leprosy.*—Presenting once again the Indian scheme, after relating the history of its development, and ending with the statement that it remains for the Indian workers "to show to the members of the WHO Expert Committee" that the maculoanesthetic group is a valid one, and that the polyneuritic cases cannot be divided among the different types on histologic grounds.

GHOSH, S. *Clinical features.*—Discussing in detail only the divisions of the nonlepromatous form: the tuberculoid, maculoanesthetic and polyneuritic "types."

KUNDU, S. *Diagnosis.*—This, it is said, depends on the finding of skin lesions together with "any one of the following diagnostic signs, namely, loss of sensation, thickened nerves, and acid-fast bacilli." For the bacteriologic examination the "slit and scrape" method [originally called the "scraped incision" method] is used.

BASU, S. P. *Radiologic bone changes and angiographic findings.*—A very condensed statement in which the speaker tells of having found bone changes in 85% of 100 unselected cases, and also tells of injecting the brachial artery above the elbow joint with a radioopaque substance (Pyelosil 35%) for arteriography of the hands, which demonstrated venous stasis.

SEN GUPTA, P. C. *Pathology.*—A story of the early course of infection, in which it is indicated that lepromin positivity depends upon production of antibodies, and upon them depends the outcome—complete suppression, or tuberculoid, or lepromatous, or "borderline or dimorphous" leprosy.

SOMERSET, E. J. *Ocular lesions.*—It is stated, in effect, that only in lepromatous leprosy is there invasion of the globe by the leprosy bacillus, so that in that type iritis is the most important complication while in tuberculoid leprosy the troubles are corneal and secondary to nerve involvement.

KHOOSHOO, P. N. *The working of the national leprosy control scheme.*—The general scheme is outlined in detail, and a progress report is given. To December 1960, with 4 treatment-study centers, there were 116 subsidiary centers in 15 provinces, and 85,168 cases (21,532 L, 60,018 N, and 3,168 "N?C") had been found among 6,129,582 people examined; but at the same time there are 112,502 known cases in the project area, with a total population of 12,784,129 (approaching 10 per thousand).

MUKERJEE, N. *Therapy.*—A summary review of existing modern drugs, which it is said have largely replaced the less effective hydnocarpus treatment. Of the sulfones, only DDS and Sulphetrone are mentioned.

LAHIRI, D. C. *Immunity.*—The lepromin reaction, it is said [surprisingly] is analogous to the tuberculin reaction in tuberculosis.

DEY, N. C. *Experimental transmission.*—A relatively long review, in which the work of K. R. Chatterjee, reported from the same institution, seems not to be strongly supported because of lack of mention of controls to eliminate murine leprosy by inoculation

of rats and [sic] guinea-pigs. [Chatterjee had negatived murine leprosy, saying that it infects his mice much more rapidly and severely.]

CHATTERJEE, N. C. *Surgery.*—A very general talk, in the course of which a digression tells of a plan to vaccinate with BCG a control group in Bankura, saying that if it turns out that it should result in a higher tuberculoid rate it would be an important landmark in the immunology of leprosy.

MUKHERJEE, M. M. *Plastic surgery.*—Listing the defects, from "depigmented patches" to dropped foot, that can be repaired with success.

SARKAR, S. K. *Physiotherapy.*—This longish general statement is said to be an abridgement of the original.—H. W. W.

EURO/EMRO INTER-REGIONAL LEPROSY CONFERENCE

Istanbul, October 2-7, 1961

An inter-regional leprosy conference involving the European and Eastern Mediterranean Regions of WHO—the fourth such inter-regional WHO meeting organized under the direction of Dr. J. Gay Prieto—was convened in Istanbul for the period October 2-7, 1961. Fifteen countries had been invited and 12 of them sent 16 participants, in addition to whom there were 7 observers from official and unofficial organizations, 3 members of the WHO secretariat, and 3 temporary consultants, for a total of 29. Dr. Ethem Utku, of Turkey, was elected chairman, and Dr. R. Rollier, of Morocco, rapporteur. The report of the Conference issued by WHO headquarters in Geneva bears a general title identical with the heading of this note, and the document identification WHO/Lep.Conf.2/11.

At the outset it is pointed out that in the vast region there are more than 223 million inhabitants of very different races, religions, customs and social conditions, with variable climatic conditions, and that the leprosy situation shows the same "polymorphism."

According to the latest information there are in total about 38,000 registered cases in the area, of which only about one-half are under treatment; the estimated total is about 100,000. It was felt, however, that it would not be possible to determine the prevalence with any accuracy until surveys have been made on the basis of:

either a sample of the total population,
or the total population in a given zone.

And yet, later on, it is noted that "in some countries leprosy is not endemic everywhere," and that "the prevalence ratio must therefore be calculated in relation to the population of the infected zone."

Discussing formulas for expressing prevalence, incidence, etc., it is pointed out that, contrary to the opinion of many leprologists, the formula

$$\frac{\text{number of lepromatous cases} \times 100}{\text{total number of leprosy patients}}$$

does not give the "infectious potentiality rate"; it should be:

$$\frac{\text{number of lepromatous cases} \times 1000}{\text{total population.}}$$

As a rule, it is stated, the higher the endemicity the lower the percentage of lepromatous cases, and this percentage tends to rise as the total number of cases decreases. (As

leprosy was at the point of extinction in Switzerland, it is pointed out, all the last cases were B+ lepromatous. In Italy the lepromatous cases are 92%, and in Yugoslavia 86%.)

The countries of the region are divided into three groups according to the estimated prevalence.[1]

(*a*) Prevalence rate 1 per 100,000 (0.01 per thousand) or less:

Italy: Prevalence 0.01 p.m. (92% lepromatous).

Yugoslavia: Prevalence 0.003 p.m. (86% lepromatous).

Bulgaria: Total 7 cases (6 lepromatous) among 8,000,000 inhabitants.

(*b*) Prevalence between 0.14 and 0.53 per 1000: Greece, Iran, Iraq, Malta, Portugal, Spain.

(*c*) Prevalence about 1 per 1000: Egypt, Morocco, Turkey.

On the whole, leprosy in the countries of the regions concerned is not as serious a problem as in most parts of Africa and South-East Asia. Actually, this statement is made in connection with the second (*b*) group of countries listed above, but it seems applicable to the region as a whole, noting however the statement made in listing the small third (*c*) group of countries that leprosy is a serious problem in them.

The second section of the report begins with the statement: "Since leprosy prevalence is low in [these countries] it does not constitute a serious threat." Nevertheless, "it creates a problem for the health services concerned," and to deal with the problem in a country effectively "there must be a specialized service."

Requirements of such a service are considered at some length. After considering his responsibilities, it is pointed out that the personality of the chief of the service will be the paramount factor in its success, but that a small Consultative Committee should be available when needed by him. Essential for such a service is a central register, and a record of contacts must also be established. Points concerned with the work at the regional and the local levels are mentioned.

Legislation "must be adapted to the new concepts with regard to the infectiousness and curability of the disease." In fact, there should be no special legislation about leprosy, and if any such exists it should be repealed.

In countries where prevalence is low, it is said, case-finding should be based on examination of (*a*) contacts, and (*b*) special groups. The Conference's definition of "contact" is not limited to a person who lives or has lived with a leprosy patient, but includes anyone whom a person with the disease "approaches or has approached continuously or at intervals in the course of daily life," in the home, or at school, or at work, etc.—"contact . . . in its widest sense." The selected groups referred to are represented by "schoolchildren, recruits for the armed forces, factory workers, etc.," and examinations are to be carried out when people gather for other health purposes, as for vaccination or outpatient consultations. Any case-finding program must, from the start, provide for the treatment of all detected cases.

In countries where health services are inadequate, the leprosy control campaign should be initiated by a pilot project in a selected zone, and specifications are given.

Regarding criteria for arrest of the disease the conference adopted the conclusions of previous inter-regional conferences as to what "inactive" cases are. [There is no provision for calling other cases anything but "active," whether they are in truth active or not—including cases which have regressed to the point of bacteriologic negativity, until six months required for "inactivity" have passed.]

It is proposed that use of the word "leprosarium" be discontinued, that it be replaced by "Institute of Leprology" [sic] or "Leprosy Sanitarium." New construction of such establishments is not recommended, but old ones should be modernized to provide for their new functions.

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[1]All but two of the countries listed below were represented at the conference, while two that were represented (Cyprus, Lebanon) are not listed.

Under treatment, it is agreed that in some parts of the regions under consideration the health conditions "are sufficiently good to make mass campaigns unnecessary." Nothing more is said on that subject. The recommendations for therapy itself are along accepted lines.

Regarding "leprosy reactions," it is said that they have increased in frequency since the introduction of sulfone therapy. In dealing with them, "the greatest attention must be paid to the concomitant associated pathological condition." [Which statement might have done with some explanatory elaboration.]

The section on methodology in drug trials, for the evaluation of new therapeutic substances, goes into some detail but ends by referring to another WHO document, WHO/PA/97-60, "Clinical Trials in Leprosy."

Regarding prophylaxis, it is said that only by systematic case-finding and regular treatment of all patients can the sources of infection be eliminated. Compulsory segregation is not favored, nor the care of children of leprosy patients in preventoria. "The separation of children from their leprous parents is not to be recommended."

About BCG vaccination, the view is expressed that, although its efficacy in leprosy has not been proved as it has been for tuberculosis, in areas where leprosy is present it cannot be other than advantageous. Chemoprophylaxis in child contacts is touched on, apparently from reports in the literature.

The subjects of teaching of leprology, training of personnel, and health education are dealt with along the lines of previous reports from WHO sources.—H. W. W.

A "FACIES LEONTINA" OF LEPROSY ON AN ANCIENT CANAANITE JAR[1]

Among the archaeological objects discovered during the excavations of the four Canaanite temples of Beth-shan in Palestine (1925-1926), there is a clay jar which arouses considerable medical interest. The earthenware vessel, of a type used for grain and flour storage in the Near and Middle East from ancient times to our days, has a human head moulded upon it. It was found among sacred and cult objects in a section of the Amenophis III temple which dates back to 1411-1314 B. C. The jar is now preserved in the Rockefeller Museum of Antiquities in the Old City of Jerusalem.

Alan Rowe, in a detailed description of the archaeology of these four Canaanite temples, identified the head on the jar as that of the Egyptian god Bes.

This jar has a head like that of the dwarf-gods Bes or Ptah-Seker-Osiris. The dwarf reminds one of the figures of dwarfs with which, according to Herodotus, the Phoenicians ornamented the prows of their boats.

On looking at the head on this jar, one is impressed immediately by the very great similarity to the "leonine facies" of leprosy. It is a striking face, affected and disfigured by the pathological changes of a progressing disease. The skin has thickened on cheeks and face and has assumed a swollen, loose appearance; the nose is disfigured; the eyebrows bulge and the hair has fallen out from them; the natural lines

[1]Excerpts from a note in the *Journal of the History of Medicine* **10** (1955) 331-332 by M. Yoeli, of the Hadassah Medical School, Hebrew University, Jerusalem, Israel, reprinted by permission. The picture reproduced is from a black-on-white photostat copy of the original publication, an actual copy of which was not obtained.

and folds are strongly exaggerated. All these morphological changes point strongly to a "leonine facies" of lepromatous leprosy.

Many authors agree today that the Biblical term "Zaraat," which has been translated as leprosy, includes a number of affections of the skin which may have been of different etiological origins. It is not known, however, whether leprosy is one of the diseases included under

FIG. 1. — Earthenware jar discovered in Amenophis III temple at Beth-shan (Palestine).

this name. To quote R. D. G. Simons:[2]

> Attempts have been made in the past—as in the case of syphilis—to discover the country of origin of leprosy. Investigations of mummies and pictures from Egypt and Asia remained unsatisfactory.

It would appear that the head on the jar from the Beth-shan excavation is an early visual representation of leprosy from Canaanite, pre-Biblical days. We cannot completely answer the question why an awe-inspiring "leonine face" of a leper should be depicted on a clay vessel used for grain storage and found in a shrine among sacred cult objects used in agricultural rites in ancient Canaanite times. It may, however, be assumed that in ancient rites of death and revival of plants and vegetation, in the cult, that is, for protection of the harvest, the terror-inspiring face had a special meaning.

It would seem, if we take into account comparative mythological studies, that the terror-striking head of a leper—the disfigured face of a man punished by the gods—is perhaps depicted on a vessel dedicated for the preservation of crops and harvest with the thought that he may act as protector.

> We recall a Biblical story which can be interpreted anew in the light of the archaeological findings at Beth-shan. It is the tale of the four leprous men at the entrance of the gate of Samaria (II Kings, Chapter 6-7). The Biblical narrator recounts in gruesome and appalling detail the great famine that had descended upon Samaria. The besieging army of Ben-hadad, King of Syria, had laid waste the land, and hunger was so great that mothers were eating their children. To the starved population and the skeptical king of Israel, the prophet Elisha, Man of God, foretold miraculous deliverance and abundance of grain and flour. We witness in very fact the terror-stricken host of Syria abandoning tents, grain supply, horses, and camp and fleeing before the imaginary noise of a mighty host sent against them by the Lord. We follow the four lepers in their errand through the abandoned camp of Ben-hadad and in their message of deliverance as they bring tidings of great abundance in flour and grain to an unbelieving populace of a starved and beleaguered city. Elisha's prophecy had come true: "It came to pass, as the man of God had spoken to the king saying, two measures of barley for a shekel and a measure of fine flour for a shekel, shall be tomorrow, about this time, in the gate of Samaria."

One can detect woven into the pattern of this tale the threads of a more ancient Egyptian-Canaanite myth which ascribed to the awesome countenance of the leper the power to protect the grain and young harvest and the might to stem famine and pestilence.—M. Yoeli

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[2]Simmons, R. D. G. Handbook of Tropical Dermatology, Amsterdam, 1952, Vol. 1, pp. 165-166.

Leprosy in Egyptian Mummies

A newspaper report from London passed on to us by Stanley Stein, of the Carville *Star,* told of a report of the ills of ancient Egyptians as revealed by a study of mummies to be published by the Royal Society of Medicine. Leprosy was mentioned among the various diseases listed. On inquiry, we were kindly supplied with a copy of the article, by J. Thompson Rowling, entitled Pathological Changes in Mummies in the

History of Medicine section of the *Proceedings of the Royal Society of Medicine* 54 (1961) 409-420. The short paragraph on leprosy is reprinted here verbatim, by permission.

Leprosy: There is little evidence to suggest that leprosy was common in Egypt. The Nubian collection contains one excellent specimen, dating from Coptic times, of the hands and feet of a body affected by advanced leprosy.

This statement supports previous information that no evidence of leprosy has been found in ancient mummies, since the one referred to was relatively recent. In another article in the same issue of the *Proceedings* the dates 400-500 A. D. are given for certain material from the Coptic times.

NEWS ITEMS

Mexico: *The work of "lepra brigades."*—In a report of the First Mexican Congress of Dermatology, held in Mexico City August 20-September 2, 1961, by M. E. Obermayer—who was present as a guest of honor—published in the *Archives of Dermatology* **85** (1962) 283-284, the following is said of leprosy: "Leprosy in all its phases was given a large place as is understandable considering its prevalence in this part of the world. 'Lepra brigades,' small groups of trained health personnel who comb the remotest portions of the country by jeep and gain the confidence of the people by staying in their humble dwellings, are a new and most constructive effort in the fight against the disease."

Former patient elected governor.—A story that originated in the *Tucson* (Arizona) *Star* tells of the political comeback of an ex-leprosy patient. In the State of Sonora, one Luis Encinas Johnson (whose last name alone might have been a handicap in Mexico), a lawyer who in his twenties had become a judge, state attorney general and legislator, and at 30 was the head of a state political party, was then found to have leprosy. For 10 years he dropped from sight, during part of which time he was a patient in a leprosy hospital in Mexico City. After his return he was named president of the University of Sonora, which he built up to a first-class university. He then returned to politics, and against strong opposition was elected governor, a position which he was to assume in September 1961.

United Kingdom: *Another new name for leprosy.*—In the 37th Annual Report of the British Leprosy Relief Association (BELRA), it is said—with approval—by the Carville *Star,* Dr. J. Ross Innes, medical secretary of the Association (and secretary-treasurer of the International Leprosy Association) proposed a new name for leprosy. "Someone must at least make an attempt" to find one, so he suggested that a scientific one might be "neurodermatosis mycobacteriana," or "mycobacterial neurodermatosis." "Though this newly suggested name is somewhat long and far from neat, it is reasonably descriptive and certainly quite free from the age-long superstitions and stigma." Imagine calling the organization which he represents, "British Neurodermatosis Mycobacteriana Relief Association"!

(It would seem that Dr. John H. Hanks, of the Leonard Wood Memorial, may be inclined to take the alternative term seriously. At least he used it—in quotes, to be sure, and perhaps jocosely—in a letter to the Carville *Star* on the occasion of its 20th Anniversary number.)

Uganda: *Trial of BCG in leprosy control.*—A trial of BCG against leprosy among contacts in the Teso district of Uganda, under the auspices of the Medical Research Council of Great Britain, is now in its second year, we are informed by Dr. J. A. Kinnear Brown, who is in charge of the work. There are now about 6,000 children in the experimental group and a like number in the control group. They are assigned to the

groups by alteration, and they are mostly related contacts although not necessarily of lepromatous cases, which are in relatively small numbers (from 6 to 10% of all cases). The first phase of the work will end in September, after which it will probably be reported. It is expected that observations will continue for some years.

Another M. ulcerans *focus.*—In a particularly interesting narrative report of a visit to Africa by Dr. Stephen Rothman, of Chicago [*Archives of Dermatology* **85** (1962) 311-324], he mentions a focus of *M. ulcerans* infection now being studied in Kampala, Uganda. Besides the original focus in Australia, and another one in the Congo (not mentioned), it is said that others have been reported from Mexico and West Africa.

India: *Prize-winning film.*—A documentary film about reconstructive surgery in leprosy, made by Dr. Paul W. Brand of the Christian Medical College at Vellore, was awarded the million-lire ($1,600) first prize at an international festival of scientific and medical films held in Pavia, Italy, last October, according to the Carville *Star.*

Japan: *Japanese Leprosy Association.*—The 35th annual meeting of the Japanese Leprosy Association was scheduled to be held on April 27-28 in Sendai, under the presidency of Dr. S. Sato, who is director of the Leprosy Section, Institute for Diseases due to Acid-fast Bacilli. Professor Sato was to deliver one of the special addresses, Acid-fast Bacilli and Fishes. Another special address, on the subject of The Rehabilitation of Leprosy Patients from the Orthopedic Point of View, was to be delivered by Prof. T. Tamai, director of the Orthopedic Clinic, Kumamoto University School of Medicine.

Korea: *Leprosy prevalence and treatment.*—The leprosy problem in the Republic of Korea is among the most serious in the Western Pacific Region, the number of persons afflicted by the disease being estimated at more than 200,000. The 20 existing leprosaria have only one doctor, who visits them periodically with a traveling clinic. There is practically no ambulatory treatment, and a large number of patients are not under medical supervision.

Dr. R. Trappmann, of Germany, has been appointed leprologist to the WHO-assisted leprosy control project started in the Republic of Korea in 1960. An outstanding dermatologist, Dr. Trappmann was for ten years clinical director of the Central Leprosy Institute, Djakarta, Indonesia. During his assignment he will encourage Korean dermatologists to cooperate in the leprosy campaign.—[*WHO Chronicle* **15** (1961) 429 (Nov.)]

United States: *Biopsy required for discharge.*—Until recently, discharge of patients from the Carville leprosarium of patients originally bacteriologically positive has been based on clinical inactivity and a year of bacteriologic negativity as revealed by a series of monthly smear examinations. Now a biopsy has been added to the requirements. It is said (Carville *Star*) that recently several patients who had successfully completed their bacteriologic tests were not discharged, apparently because of the biopsy findings. Heretofore, to our knowledge, only Brazil had had the drastic requirement of a biopsy before discharge. The new requirement would seem to be contrary in spirit and logic to the issuance, under certain circumstances, of "medical discharges" for patients still bacteriologically positive in smears.

New committee of American Leprosy Missions.—Dr. Oliver W. Hasselblad, president of the American Leprosy Missions, has announced the formation of a medical committee to advise on the recruitment and training of leprosy workers. With the provision by governments and intergovernmental agencies of things that used to be the main concern of the Mission organization—food, clothing, buildings and equipment, and medicines—"the scarcity of trained personnel is now of critical importance to all leprosy work."

Annual seminar for missionaries at Carville.—Early this year it was announced by Dr. Edgar B. Johnwick, officer in charge of the Federal Leprosarium, according to the *Star,* that the third annual American Leprosy Missions-Public Health Service seminar on leprosy would be held April 5-11, 1962. These comprehensive seminars are planned for missionaries who happen to be in the country, chosen by the American Leprosy

Missions. They are conducted by members of the Carville staff, with contributions by selected consultants from elsewhere in the country.

Perry Burgess' "Who Walk Alone."—In a recent issue of *This Week* magazine it was reported that this book, written before the sulfone era, was among the top ten favorites of American teenagers. The *Star,* which called attention to this fact, wished that a similar interest might be taken in a more recent and up-to-date book, but it neglected to note what book would meet the requirements.

PERSONALS

DR. FAUSTO CASTELO BRANCO is reported to be director of the National Leprosy Service of Brazil, vice Dr. Joao Baptista Risi who was appointed to that position when Dr. Orestes Diniz retired as director general of health of Brazil.

DR. PAUL T. ERICKSON, who for five years was the clinical director of the Carville leprosarium, has retired from the U. S. Public Health Service and has accepted a position with the Georgia State Department of Health, Atlanta, Ga.

DR. K. HAMANO, executive secretary of the Tofu Kyokai, in Tokyo, together with DR. R. YAJIMA, director of the Kuryu Rakusen-en National Leprosarium, has recently visited Hawaii to see the Kalaupapa Settlement.

DR. EDGAR B. JOHNWICK, officer in charge of the Federal Leprosarium at Carville, La., was paid a public tribute at a patients' Christmas party last year for his accomplishments in improving the institution in his five years of service.

DR. KANEHIKO KITAMURA, head of the Department of Dermatology of the Tokyo Medical College Hospital and Contributing Editor for Japan of THE JOURNAL, plans to attend the 12th International Congress of Dermatology, to be held in Washington, D. C., September 9-15, where he will participate in two symposia. It is said that Dr. Rubem D. AZULAY, of Rio de Janeiro, Brazil, intends to visit Japan after the Congress.

DR. JOHN H. S. PETTIT, recently professor of dermatology at the University of Shiraz, Iran, has joined the staff of the British Medical Research Council and is now in charge of the Leprosy Research Unit, Sungei Buloh Settlement, Selangor, Malaya, succeeding Dr. M. F. R. Waters.

JOHN A. ROBERTSEN, Ph.D., for nearly four years microbiologist in the laboratory of the U. S. Public Health Service Hospital (Federal Leprosarium) at Carville, La., has resigned from the Service to join a newly formed research group in tropical medicine with the Pitman-Moore Company, Indianapolis, Indiana. He will, nevertheless, continue as Contributing Editor of THE JOURNAL for the continental United States.

DR. R. TRAPPMANN, of Germany, a dermatologist who for ten years was the clinical director of the Central Leprosy Institute at Djakarta, Indonesia, has been appointed leprologist to the WHO-assisted leprosy project in Korea.

DR. M. F. R. WATERS, who for nearly three years has been in charge of the Leprosy Research Unit at the Sungei Buloh Settlement, is returning to England to continue his work at the National Institute for Medical Research, London.

DR. Y. YOSHIE was recently appointed director of the National Leprosy Research Institute, Tokyo, replacing DR. R. KOBAYASHI, retired.