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EDITORIALS

Editorials are written by members of the Editorial Board, and occasionally by guest editorial writers at the invitation of the Editor, and opinions expressed are those of the writers.

A Message From The President

On the International Leprosy Association

Of all the diseases that have afflicted, and still afflict mankind, leprosy has been known for more than three millenia as a skin disease dreaded for its ravages, its progressive evolution and its supposed infectivity. I refer very especially to its severity in its lepromatous form. We do not know to what extent the word "lepra" as used by the ancients designated the disease as known clinically in our time, but human remains in ancient and medieval tombs show skeletal changes that do not differ from those of advanced cases as we know them. The disease was endemic in all parts of the ancient world and the patients lived mostly as miserable outcasts.

The middle ages saw a betterment of the patients' lot in Europe. The care of the afflicted became the virtue of saints and the redemption of sinners. Thousands of hospices were built and maintained by religious organizations. Laws were enacted to ensure that the poor would share equally with the rich in the protection of the hospices. Those laws required the strict seclusion of the patients, but discrimination or laxity in their enforcement gave the patient much liberty to move about in his distinctive cloak, with his tall hat, his staff and his warning clappers. The oblique holes in the thick walls of old churches, through which the patients peeped toward the altar, bear witness to the prevalence of leprosy everywhere in medieval Europe. If the physicians of those times had any better means of treatment than prayers and incantations, besides extracts of nodular roots for nodular lesions, they have not been transmitted to us.

During the last two centuries leprosy has ceased to be an endemic disease of major concern in Europe. It is a strange coinci-

dence, however, that tuberculosis has advanced as an urban disease as leprosy has disappeared in rural districts. In Asia and Africa leprosy still persists in practically undiminished endemicity, and the life of the patients is often similar to what it was in Europe in ancient times. In South America the disease is endemic in very many parts and the condition of the patients leaves much to be desired

As viewed in retrospect we have only recently come out of a long night of suffering for the patient and a feckless groping of medical men for a clue as to the origin of the disease. The first glimmer of dawn came when Gerhardt Armauer Hansen of Bergen, Norway, discovered the leprosy bacillus in 1873. From that time on investigators have been able to concentrate their efforts on the elimination of that bacillus from human tissue. Many medicaments have been tried unsuccessfully. Among these chaulmoogra oil held sway as almost the only form of therapy for more than twenty years, though the percentage of patients becoming bacteriologically negative was dishearteningly low.

With the synthesis of the sulfone drugs by Gerhard Domagk, new possibilities of successful antileprous therapy were in sight. We owe it to G. H. Faget, who used promin at Carville, Louisiana, as early as 1941, and to the subsequent trials with diaminodiphenyl sulfone, now commonly known as DDS, by R. G. Cochrane in India, that the latter drug and its derivatives became the standard medicaments in antileprous therapy. Regression of lesions and an ultimate cure are now the expected results and failure the exception. The treatment is purely chemotherapeutic. The bacilli will usually disappear from the skin after long treatment, but the genetic situation in the patient that makes their proliferation possible will remain unchanged. This makes it necessary to treat the patient with little interruption throughout his life.

The use of the Calmette-Guerin vaccine, commonly known as BCG, was first practiced by J. M. M. Fernández in the Argentine. It has been considered as a means of inducing resistance to leprosy infection in lepromin-negative persons in endemic areas, but a definitive evaluation of its results is still to be made.

As a means of stimulating leprosy research the International Leprosy Association was founded in 1931, due in a great part to the initiative of H. W. Wade who, as editor of the INTERNATIONAL JOURNAL OF LEPROSY, became the moving spirit in the investigations carried on for nearly 30 years with emphasis on histopathology and the classification of types, as well as on chemotherapy. The biochemical approach, though not entirely ignored, was kept in the background due to Wade's characteristic sense of caution.

Until the end of 1968 the Leonard Wood Memorial of Washington contributed the greater part of the cost of publishing THE JOURNAL.

We know now that the leprosy bacillus is an intracellular parasite of the tissue macrophages, which will destroy them in normal persons, but fail to do so in lepromin-negative individuals. Recent research strongly indicates that a negative lepromin test is due to a genetic defect that prevents the lymphocytes from synthesizing a factor that the tissue macrophages require specifically in order to destroy the bacilli. The existence of the so-called transfer factor has been demonstrated in connection with tuberculosis and research should be directed towards the isolation of an analogous factor as regards *Mycobacterium leprae*. It stands to reason that we shall have a natural means of prophylaxis and early treatment if the factor could be produced from cultivable microorganisms including the lymphocytes themselves. Its presence in these may not be a single instance of its natural occurrence. It would be worth while investigating if its synthesis could not be induced in some bacteria-feeding protozoan.

Apart from stimulating antileprosy research, the International Leprosy Association should be dedicated to the protection of leprosy victims against superstition or erroneous popular concepts regarding the disease and especially against the obligatory sterilization that has been the object of misguided legislation in India.

When hospitalization is required, its sole objects should be to make sure that the patient receives a more regular treatment

than would be possible in his home at his own discretion. His civil status should not be different from that of any other man suffering from a chronic disease.

In the present organization of the ILA the members of the Council are located on four continents within reach of endemic areas. It should be their task to promote dynamic action in the antileprosy campaigns by educating the public about the facts of the disease and to represent the Association before the governments in efforts to persuade them to provide ample funds for combating the disease wherever its endemicity is a serious problem. Their task should include the preparation of medical students to enable them to detect new cases and to keep the disease from spreading beyond existing foci.

The influence of the ILA is exercised through the decisions taken at its Quinquennial International Congresses. The appointment of a general committee to collaborate with a local committee at the site chosen for a congress should be made long before it convenes in order to give it the greatest possible chance of fulfilling its purpose.—JACINTO CONVIT, M.D.