LEPROSY IN ENGLAND

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A great majority of the persons with leprosy who are seen in England have contracted it abroad, and by the time they have seen a physician it has already entered into an advanced stage. The opinion is general that the danger of transmitting the disease in this country is negligible, at least so far as adult members of the community are concerned. However, there is some evidence that contact cases may arise here. The writer has personal information concerning three of these, and considers a fourth one with which he is in touch also a contact case of local origin. The difficulty in proving that a case has arisen from contact with another case in this country is that it must be proved that the patient has never been in an endemic center of leprosy. Certain workers hold that as a general rule the disease is acquired largely in childhood or early adolescence, and it would appear that even in great Britain there is at least some danger to young adolescents or children should they come into contact with open cases of the disease.

The writer subscribes to the general view that conditions in England do not tend to cause the spread of leprosy. One of the striking points in recent cases which have come under notice is the relatively long latent period. In one instance this period was thirty years, and in another instance fourteen years. Another point that is very prominently brought to one's attention is the fact that most individuals that have been seen have usually been to several physicians before they have been diagnosed. By that time they have practically all reached the C1-N2 or C2-N2 stage, and a certain number of them have become arrested secondary neural cases. This, unfortunately, is inevitable where, as here, leprosy is a comparatively rare disease and the diagnosis is consequently seldom considered. Actually cases are sufficiently numerous in England—probably between 70 and 100—that the general physician should remember that he may come across it.

The prognosis of the cases seen is usually poor, probably for two reasons. First, though the average European is resistant to the disease, if that resistance is broken down he usually acquires it in an active form. Second, climatic conditions in this country are detrimental. In fact, it appears to be advisable for patients to remain in the country in which they acquired the disease rather than be sent home for treatment, unless they happen to be living in a tropical country where the health conditions are notoriously bad. The majority of physicians treating leprosy in this country are definitely pessimistic with regard to the results of treatment, and much of this pessimism is entirely justified. In my own experience the majority of cases progress from bad to worse—largely because, as I say, the disease is already in the advanced stage when discovered.

The treatment at the St. Giles Homes is quiet up to date. Though most of the patients have little likelihood of cure, a great deal can be done to alleviate their condition. As elsewhere, the basis of treatment is some derivative of chaulmoogra oil. When intradermal injections are indicated the esters or creosoted oil is given in that way. The latter preparation is the more generally used because of the persistence of staining from the iodized esters. Many advanced cutaneous patients cannot stand injections, sometimes on account of reactions, and in such cases oral administration of modern refined oil is useful. This is also to be advocated when all lesions that can be treated intradermally have been injected, or when there are no such lesions. Other remedies are also used, such as potassium antimony tartrate where indicated; solganol B oleosum in small doses given in courses of six weeks, especially in sub-reaction stages of cases prone to lepra reaction; and for the reduction of nodular carbon dioxide snow applied for from 20 seconds to 1½ minutes according to the size and density of the lesions.