NEWS and NOTES

This department furnishes information concerning institutions, organizations, and individuals engaged in work on leprosy and other mycobacterial diseases, and makes note of scientific meetings and other matters of interest.

XII International Leprosy Congress

ILA delegation meets with Prime Minister Indira Gandhi. From left to right: Mrs. Gandhi, unidentified, Dr. Stanley Browne, Prof. Michel Lechat, Dr. R. H. Thangaraj.

Prime Minister Indira Gandhi to speak at XII International Leprosy Congress. On 16 June 1982 Mrs. Indira Gandhi received a delegation of the International Leprosy Association and kindly accepted to give an address at the opening ceremony of the XII International Leprosy Congress to be held 20–25 February 1984 in New Delhi, India.

The ILA delegation was composed of Professor Michel F. Lechat, President of ILA; Dr. Stanley G. Browne, Secretary General of ILA; Dr. Dharmendra and Dr. R. H. Thangaraj, Working Chairman and Organizing Secretary of the Local Organizing Committee of the Congress, respectively.

We reproduce below detailed information relating to the Congress.

Revised Dates and Second Information Bulletin

The revised dates of the Congress are 20–25 February 1984, and the Second Information Brochure will be sent to all concerned by November 1982. The forms for registration, hotel accommodations, and other details will be dispatched before the end of this year (1982) to all those who have sent or will now send in their "Intention to Register."

Workshops

The following Workshops will be organized before the Congress Sessions from 16–18 February 1984. The venue is Vigyan Bhavan, New Delhi. The Chairmen and Core Members have already been chosen and notified.

1. Experimental Leprosy
2. Microbiology
3. Immunology
4. Experimental Chemotherapy
5. Epidemiology and Control
6. Teaching and Training
7. Social Aspects

Sessions of the Congress

The Congress sessions will be held from 20–25 February 1984. Registration counters will be open from 19–25 February 1984.

The following are the Main and Concurrent Sessions of the Congress:

Main Sessions (Main Hall)

Date 1984	Day	Time		Topic
		From	To	
20 February	Monday	Forenoon		Registration.* Opening Ceremony Keynote Address
		2 P.M.	5 P.M.	Clinical Aspects
21 February	Tuesday	9 A.M.	1 P.M.	Immunology I
		2 P.M.	5 P.M.	Immunology II
22 February	Wednesday	9 A.M.	1 P.M.	Microbiology
		2 P.M.	5 P.M.	Experimental Leprosy
23 February	Thursday	9 A.M.	1 P.M.	Epidemiology and Control I
		2 P.M.	5 P.M.	Epidemiology and Control II
24 February	Friday	9 A.M.	1 P.M.	Social Aspects
		2 P.M.	5 P.M.	Social Aspects

Concurrent Sessions (Commission Room)

Date 1984	Day	Time		Topic
		From	To	
21 February	Tuesday	9 A.M.	1 P.M.	Surgery and Rehabilitation
		2 P.M.	5 P.M.	Ophthalmology
22 February	Wednesday	9 A.M.	1 P.M.	Treatment
		2 P.M.	5 P.M.	Nerve Damage
23 February	Thursday	9 A.M.	1 P.M.	Experimental Therapy

Delegation Fees

Currency	Delegates		Associates	
	Before 30 September 1983	After 30 September 1983	Before 30 September 1983	After 30 September 1983
Indian Rupees	Rs. 1000	1200	Rs. 500	600
U.S. $	$ 120	150	$ 60	75
£ Sterling	£ 60	80	£ 30	40

* Registration will be open from Sunday, 19 February 1984.

Abstracts

Instructions to Authors.

1) Abstracts will be considered only from authors who fully intend to attend the Congress.
2) No author may appear as the first or principal author of more than one paper.
3) Abstracts may be submitted in any of the three languages of the Congress—English, French, or Spanish.
4) Abstracts should not exceed 200 words in length.
5) No tables or graphs should be included in the abstracts.
6) Abstracts should be submitted in four copies, typed in double spacing, with adequate margins left and right.
7) The session at which the paper would be appropriate should be indicated at the top of the abstract.
8) The names and initials of the authors should be given, with the institutions where the principal or first author works. Degrees and titles are not required.

Note: Abstracts will be considered by a Special Committee, appointed by the President, which reserves the right to decide which paper shall be read in full, which read by title only, and which is recommended for poster presentation. (Facilities for poster presentation are available at Vigyan Bhavan.) Abstracts should reach Dr. S. G. Browne at the following address not later than 30 June 1983. Any abstracts received after that date will not be considered.

Dr. S. G. Browne
Secretary General
International Leprosy Association
16 Bridgefield Road
Sutton, Surrey, SMI 2DG
England

Teaching and Training Sessions

A new feature at this Congress will be the introduction of Teaching and Training Sessions through slide, tape, and video presentations. The subjects chosen for these sessions are:

1) Clinical examination
2) Reactive phenomena
3) Clinical and histological types—delineation (New Indian Classification)
4) Education on public and patients
5) Nerve damage and anesthetic limbs
6) Ocular manifestations
7) Approaches to leprosy control
8) New undertakings of immunology

These sessions will take place in blocks of time. The whole of a morning or an afternoon being given to repeated presentation of one topic. Each session whether by slide, tape, or video presentation will be approximately 50 minutes. This program is being introduced to:

1) offer basic instructions in aspects of leprosy to delegates, and to
2) demonstrate to delegates some of the teaching material available.

Official Carrier

Air India International has been appointed as the official carrier for the Congress. Air India is offering various reduced fares to delegates. Please contact the Air India representative in your country for detailed information.

Official Travel Agents

India Tourism Development Corporation (ITDC) have been appointed as the official travel agent for hotel accommodations, transportation, arrangements for ladies programs, pre- and post-Congress tours, travel confirmation, ticketing, and food arrangements. Lunch tickets at cost will be distributed by ITDC by earlier arrangements or at counters.

The following hotels have been selected for accommodating the delegates. The ITDC has assured us of a 10% discount of the accommodation charges.

Hotel	Single	Double
Ashok	Rs. 600/day	Rs. 700/day
Akbar	Rs. 500/day	Rs. 600/day
Kanishka	Rs. 400/day	Rs. 475/day
Qutab	Rs. 325/day	Rs. 400/day
Janpath	Rs. 250/day	Rs. 350/day
Lodi	Rs. 225/day	Rs. 290/day
Ranjit	Rs. 200/day	Rs. 260/day
Yathrinivas	Rs. 70/day	Rs. 90/day

These charges are valid up to 30 September 1983 and will probably be revised by 1984 as per travel trade practice in India. The charges do not include food. ITDC will require two days' advance rent for confirmation of accommodations.

Pre- and Post-Congress Tours

Pre- and post-Congress tours will be organized by the ITDC. For particulars of these tours, please write to or contact Mrs. Kamala Sehgal at the following address:

Mrs. Kamala Sehgal
Dy. Divisional Manager (Marketing)
India Tourism Development Corporation
Room No. 296, Ashok Hotel
50-B, Chanakya Puri
New Delhi 110021, India

Tentative Program

The tentative program of the Congress is as follows:

Sunday, 19 February 1984

Registration (registration counters will be open daily from 19–25 February 1984 at the Vigyan Bhavan)

Monday, 20 February 1984

(Morning) Inauguration by the President of India
Keynote address by Smt. Indira Gandhi, Prime Minister of India

12:30 P.M.–2 P.M. Lunch (free for all delegates)

2–5 P.M. Scientific Session

8 P.M. Dinner hosted by the Chairman of the Local Organizing Committee and the President of the International Leprosy Association (for delegates and especially invited guests)

Tuesday, 21 February 1984

9 A.M.–1 P.M. Scientific Sessions

2 P.M.–5 P.M. Scientific Sessions

7:30 P.M. Cultural Program

Wednesday, 22 February 1984	
9 A.M.–1 P.M.	Scientific Sessions
2 P.M.–5 P.M.	Scientific Sessions
Thursday, 23 February 1984	
9 A.M.–1 P.M.	Scientific Sessions
2 P.M.–5 P.M.	Scientific Session
8 P.M.	Banquet (Contributory at Rs. 250/- or U.S. $30)
Friday, 24 February 1984	
9 A.M.–1 P.M.	Scientific Session
2 P.M.–5 P.M.	Scientific Session
Saturday, 25 February 1984	
9 A.M.–1 P.M.	Closing Session

Miscellaneous

Exhibits. Participants who want to bring in exhibits should inform the Organizing Secretary by 31 March 1983. We need to get the customs clearance from the Ministry of Commerce. Exhibitors are requested to detail the exhibits with value and the port of entry in India. They have to give an undertaking that these exhibits will not be sold after the Congress is over.

Interpretation. English, French, and Spanish.

Documentation. English, French, and Spanish.

Showing of Films. Showing of films of a general nature will be limited to Wednesday, Thursday, and Friday (22, 23, and 24 February 1984). The films will be previewed on 20 and 21 February 1984. Technical films will be presented without preview in the technical sessions.

Projection Equipments. All the halls are provided with 35 mm slide projectors and 16 mm movie film projectors with sound facilities. However, the halls are not fitted with super 8 mm movie film projectors.

Dress. February is a cold month in Delhi. Temperature falls to as low as 12°C to 15°C. Dress informal, but delegates are advised to bring warm clothing.

Important Notice. Over 1000 delegates from nearly 134 countries are expected to attend the Congress. Entry to Technical Sessions will be restricted to registered delegates only. The Congress badge should be worn at all times during the period of the Congress.

(The above information is released under the signatures of Shri N. R. Laskar, Chairman; Dr. Dharmendra, Working Chairman, and Dr. R. H. Thangaraj, Organizing Secretary, of the Local Organizing Committee, XII International Leprosy Congress, 1 Red Cross Road, New Delhi 110 001, India.)—(*Adapted from* Congress Information Brochure)

Brazil. *IV Brazilian Congress of Hansenology.* Held in Porto Alegre (19 October–1 November 1982), the Congress was very well organized by Drs. Bernardi, Ferreira, and collaborators. From the reception of the participants at the airport until the end of the scientific activities, the smallest details were taken care of.

There were a total of 246 participants from Argentina, Belgium, Canada, France, Mozambique, Uruguay, United Kingdom, United States, Venezuela, and Brazil (states of: Rio de Janeiro, Sao Paulo, Parana, Santa Catarina, Minas Gerais, Mato Grosso do Sul, Piaui, Rio Grande do Norte, Rio Grande do Sul, Pernambuco, and Para).

Several participants from abroad, Drs. Cardama, Convit, Gatti, Hastings, Jopling, Lechat, Noussitou, and Sansarricq, actively participated in the conferences, meetings, panels, workshops and courses. The Congress was preceded by three workshops on the following subjects: classification, control programs, and rehabilitation.

The Congress' sessions began on 30 October 1982 with free communication. This consisted of two conferences and 13 papers dealing with immunotherapy and immunoprophylaxis, the growth of *Mycobacterium leprae* in nude mice, health education, immunology, procreation of nine-banded armadillo in captivity, reactional states, teaching, rehabilitation, and diagnosis.

The second session on 31 October began with a panel on classification consisting of four papers dealing with reactional states, the comparison between the Madrid and Ridley-Jopling classifications, discussion of the practicality of the Ridley-Jopling classification in leprosy control programs, and a simplified classification of hanseniasis for control programs. The session on epidemiology and control consisted of a panel followed by a presentation of 13 papers. In the panel, a discussion of the present leprosy situation in the world, prospects for controlling leprosy, age factors in the epidemiology of leprosy, the OMSLEP system of registration and notification of leprosy cases, and the fundamentals of data registration were discussed. Different aspects of the epidemiology and control of the disease in several states in Brazil were considered in the 13 papers which followed the panel discussion.

On the evening of 31 October, additional works were presented, consisting of six papers, one of which dealt with an attempt to cultivate *M. leprae* in the plasma of lepromin-negative individuals.

The final day of the Congress began with the laboratory session consisting of a panel followed by the presentation of 11 papers. In the panel the importance of immunopathology in the etiopathogeny, the study of lymph nodes, the identification of *M. leprae* by the competence test, and reflections about the improbability of an effective antileprosy vaccination were discussed.

The afternoon session of 1 November was devoted to therapy. The panel discussion dealt with surgical rehabilitation, sulfone resistance, the therapy of reactions, the present status of chemotherapy, and the therapy of neuritis. The panel was followed by an additional four papers, including a double-blind trail to compare the efficacy of German and Brazilian thalidomide in reactions. Seventeen papers were presented in posters dealing with clinical aspects, epidemiology, control, and immunology.

Judging from the quality and number of participants, the quality of the conferences, workshops, panels, and papers, as well as the organization of the Congress, the meeting was highly successful and highly stimulating for those who attended. The organizers of the Congress as well as the participants are to be congratulated for this achievement.—L. M. Bechelli

China. *National Workshop on Detection of Dapsone (DDS) in Serum and Urine held by Institute of Dermatology, CAMS.* A national workshop on the detection of DDS in the serum and urine of leprosy patients, sponsored by the Ministry of Health of the People's Republic of China, was held at Taizhou, Jiangsu Province, 16–27 October 1982. Participants from 23 provinces, municipalities, and autonomous regions, including three leprologists and 22 laboratory technicians, were present. The training programs of the workshop were:

1) The qualitative method for the detection of DDS levels in serum and urine with Bratton-Marshall's method modified by Dr. Wu Qin-xue.

2) The qualitative methods for the detection of DDS levels in urine with two kinds of filter papers according to the reports of Prof. L. K. Seydel and Dr. Ashok Kumar, *et al.*

3) The quantitative method of creatinine (alkaline picric acid method) and dapsone/creatinine (D/C) ratios in urine with Dr. G. A. Ellard's method.

The history of DDS detection and recent advances in methodology, together with the principles and problems of the various methods, were presented in lecture. Every participant joined in the practical work of the tests. Views were exchanged between the participants and experts on leprology and the criteria of grading the Bacteriologic Index (BI) and Morphological Index (MI) were also discussed.

Prof. Ye Gan-yun, Deputy Director of the Institute, made a detailed report on his impressions in leprosy control and research activities during his recent study tour of eight countries and lectured at the closing ceremony.—Dr. Wu Qin-xue.

Dominican Republic. *III Meeting of the Standing Committee of Leprosy Control in the Caribbean* (SCLCC III). The third meeting of Leprosy in the Caribbean was held in Santo Domingo 7–9 June 1982 to discuss the control activities and to observe the development of a combined leprosy and tuberculosis program supported by the Damien Foundation in the Region V of the Dominican Republic. The meeting was attended by 15 participants from 11 countries.

Recommendations of the meeting were as follows:

1) In view of the encouraging start made in the LDC leprosy control program every effort should be made to ensure the necessary support for its continuation and further extension.
2) All countries with ongoing leprosy programs be encouraged to include this program in their PAHO AMPES program plans with the appropriate PAHO assistance.
3) In some countries (e.g., Trinidad and Tobago and Cuba) there has been a marked fall in the numbers and percentage of new cases in children under 15 years of age, suggesting a successful national program; while in others (e.g., Surinam, Guadeloupe, Dominican Republic) there was either an increase in new cases under 15 years of age or no decrease. The change in the number and proportion of new cases in children under 15 years should be utilized as an indicator of the progress of a national program and future reports to the committee should analyze in detail the new cases each year by five-year age groups (0–4, 5–9, . . . , 25+).
4) Because of the difficulties in implementing short intensive training in leprosy for non-medical decision makers, such training should be incorporated as part of the ongoing PAHO/CARICOM management programs.
5) Since the medical undergraduate teaching program has been well received in all three campuses of U.W.I., this training should now be extended to include topics such as the immunology of leprosy.
6) For purposes of comparability, a common definition of contact should be adopted, as outlined in the text of the report.
7) Recognizing that case finding and the delivery of effective therapy are the main priorities in leprosy control programs, all programs in the region should adopt short-term, combined therapy along the general lines of the report of the 1981 WHO Study Group on the Chemotherapy of Leprosy with such modifications as may be necessary under local conditions.

   It was further recommended that all patients, regardless of classification, be placed on short-term, triple-drug regimen for the recommended 6 months and 24 months for paucibacillary and multibacillary patients, respectively, and that at each monthly supervised visit, dapsone (DDS) or acedapsone (DADDS) also be administered.
8) In view of the short-term, intensive treatment regimens now being adopted, at least 90% attendance should be the criteria for classification of "regular attendance" and 100% of the supervised doses should be administered for the satisfactory completion of treatment.
9) That a protocol be drawn up or adapted to evaluate adequately the toxicity and side reactions to new short-term drug regimens, particularly with reference to Type I and Type II leprosy reactions and to relapses.
10) In view of recently confirmed resistance of *M. leprae* to rifampin in one of the countries of the Caribbean, compilation of data on suspected and proved resistance to the anti-leprotic drugs should be undertaken on a regional basis and responsibility for such compilation be vested in Dr. Richard Keeler of Trinidad, who would be willing to undertake this responsibility.
11) Evaluation of the results of short-term, combined chemotherapy in new patients should be based principally on regular six-month follow-up for three years for paucibacillary

and at least five years for multibacillary patients, to detect evidence of relapse. Patients already under long-term therapy and bacteriologically negative, should receive a short course of combined therapy (unless they have already received a course of rifampin), then released from control and followed-up for three years.

12) The extension of the Venezuelan vaccination trial as a research project to one or two of the AMRO-0510 participating countries which show high levels of leprosy prevalence should be considered.
13) Three or four of the larger on-going regional leprosy control programs which will be implementing the short-term, combined treatment regimens offer a valuable opportunity for evaluating the effectiveness of these regimens. TDR funds available at CAREC could be utilized for developing protocols for this purpose.
14) That CAREC be requested to extend its laboratory proficiency testing program to include leprosy in relevant laboratories in the Caribbean. A regional proficiency testing laboratory could also be selected.
15) While the 1981 PAHO LEP-1 form provides all the data required at the international level, countries participating at SCLCC meetings should present the evaluation of their national programs in the format of the OMSLEP Detection and Annual Statistics forms.
16) Although the Dominican Republic combined tuberculosis-Hansen's disease program in the eastern region is in its early stages, it should be pursued with vigor and with increased emphasis on its TB component with a view to eventual extension in the Republic. It is identified as a program which could be encouraged for adoption in other countries.
17) The agenda for the next SCLCC meeting should include an item on secondary prevention and rehabilitation.
18) The III meeting having been completed in the excellent facilities provided in Santo Domingo, and congenial atmosphere generated during the workshop, the government of the Dominican Republic, the Dermatological Institute, the office of the PAHO/CR, and all the staff concerned be thanked for the hospitality extended and for the valuable contributions made for the success of the meeting.
19) The invitation of the government of Cuba to host the Committee's IV meeting in 1984 be accepted.

The meeting was organized by the Pan American Health Organization/World Health Organization (PAHO/WHO) with financial support from Emmaus Switzerland and the Sasakawa Foundation.—(*Adapted from* conference materials provided by Dr. F. Luelmo)

India. *German Leprosy Relief Association Rehabilitation Fund (GLRARF) services.* The German Leprosy Relief Association (GLRA) joined the fray in India's fight against leprosy in 1957 by starting a leprosy relief rural center in Chettipatty, Tamil Nadu. The activities of GLRA over the years increased many-fold. The ever-increasing demand from various projects necessitated the creation of a Regional Secretariat in India in 1966. Over the decades, the number of hospitals, rehabilitation centers, and leprosy control projects increased to 77. The activities in India multiplied at a rapid speed, and the proposal for newer and newer ventures added to the existing Regional Secretariat.

Leprosy is a problem disease even to this day, more than a hundred years after its causative organism was discovered. To individual sufferers, leprosy brings about two stigmata—one from the disease and its neuropathic manifestation resulting in disabilities, and the other due to social ostracism.

When we think of rehabilitation of a leprosy patient, we have to take into consideration the family unit to which he belongs in recognition of the concept of the disabled family, for if one member of a family is disabled, then by definition of the word family, the family itself is disabled. This has a dual effect. Firstly, it keeps the essential family bondage and interpersonal relation-

ships intact and, secondly, it restores the individual's self respect and dignity.

In ancient days, patients were put in a big home and given food and shelter only. But most of the patients were not willing to stay for a long period, and so were forced to come out of the home and live in normal society.

Based on the above facts, we have started a domiciliary rehabilitation program with the following objectives:

1) To cater to the needs of leprosy patients who are physically disabled and at the same time mentally disturbed.
2) To speed up the process of their social assimilation and slowly wipe out the social stigma attached to the disease.
3) To rehabilitate them in their natural home environment through different services, such as helping to reactivate traditional occupations, starting fresh ones, placing for academic course, job settlement, etc., whichever suits their needs, capacities, and aptitudes.

This rehabilitation scheme was instituted with a bank fund of Rs. 400,000. The accrued interest has been utilized to meet the various expenditures.

Programs

The GLRARF programs were begun in 1974 at Madras to rehabilitate the cured patients in their natural home environment through different services, such as helping to reactivate traditional occupations, starting fresh ones, placing for academic courses, job settlement and training, etc., which are suitable to their needs, capacities, and aptitudes.

From the beginning of 1974 until December 1981, the programs expanded and now include:

1) Revolving Fund Loan Scheme,
2) Nationalized Banks Participation in Rehabilitation,
3) Training and Job Placement,
4) Children's Education Program, and
5) Sheltered Workshop-cum-Training Center.

Nationalized Banks Participation in Rehabilitation. After studying the success of our loan scheme program, the nationalized banks came forward to help the patients. The banks have helped 98 leprosy patients with loans amounting to Rs. 77,000/. Since most of our patients are repaying regularly, the banks are interested in helping more of them. Most of the patients get surety for borrowing from the loan program but for those who do not, the rehabilitation department stands as surety for them. Thus our funds are utilized for the needy, deserving patients.

Training and Job Placement. Nearly 165 patients were helped to obtain some suitable job based on their training.

Children's Education Program. Nearly 70 children are supported every year for education purposes. Each child gets Rs. 100/- in the beginning of the school year to buy the uniform, books and to pay the school fees. These funds are raised through local resources only. Apart from this, we will help deserving children in placement in local schools or orphanages for better educational purposes.

Sheltered Workshop-cum-Training Center. One of the milestones is our sheltered workshop-cum-training center. Through GELRA Plastics, we were able to help handicapped people as well as cured patients. Nearly 15 of them benefitted from this center. A few others got training in the plastic trade with job placement in the outside units, and two patients have started their own plastic unit. In addition to this, we have started a small welding unit and plan to start small industrial units for the trained patients as well.

Local participation. In addition to the specific GLRARF programs we have contacted local social clubs and a few individuals for support. The Madras Round Table No. 3 is supporting 48 children a year, and the Lion's Club and a few people are supporting the rest of the children. We are approaching more people in order to obtain financial assistance for support of the children.

In addition, we are contacting the local people for their assistance. Two of our patients received a tricycle through the State Bank of India and the Lion's Club. The Lion's Club 324A provided micro-cellular chappals and dark glasses for 55 patients, and hearing aids were supplied for a young boy and girl.

The Rotary Club has provided an auto-rickshaw for one of our patients, and the Y8s Men's Club is helping, through the re-

habilitation program, five patients to start different trades. Total achievement of the program is carried out through the team approach and there is intensive follow up of the patient.—(*Adapted from* an article by William Gershon and G. R. Srinivasan)

U.S.A. *Carville Director appointed Acting Division Director.* On 25 October 1982, Dr. John R. Trautman, Assistant Surgeon General and Director of the National Hansen's Disease Center, Carville, Louisiana, was named Acting Director, Division of National Hansen's Disease Programs, Bureau of Health Care Delivery and Assistance. The announcement was made by Dr. John E. Marshall, Acting Director of the Bureau of Health Care Delivery and Assistance. The Division of National Hansen's Disease Programs is responsible for all federally supported out-patient care as well as in-patient care for Hansen's disease patients in the United States. Dr. Trautman will remain as Director of the National Hansen's Disease Center in Carville.

John R. Trautman, M.D., ASG

Clinics have been established in the following U.S. locations for Hansen's disease out-patients:

Area	Facility	Address	Project Director
Los Angeles	L.A. County USC Medical Center, Outpatient Clinic	1175 N. Cummings St., L.A., CA 90033	Dr. Thomas H. Rea
San Francisco	Mary's Help Hospital	1900 Sullivan Ave., Daly City, CA 94015	Dr. Robert Gelber Dermatology Hansen's Clinic
San Diego	N. San Diego Health Center, Hansen's Clinic (in-patients referred to University Hospital)	2440 Grand Ave., San Diego, CA 92109	Dr. Antonio Lopez Hansen's Clinic
Seattle	Public Health Hospital, Preservation and Development Authority	1131 14th Ave. South, Seattle, WA 98144	Dr. James Harnisch Dermatology Hansen's Clinic
Staten Island, N.Y.	Bayley-Seton Hospital	Bay St. & Vanderbilt Ave., Staten Is., NY 10304	Dr. William Levis Dermatology Hansen's Clinic
Boston	Allston-Brighton Aid and Health Group, Inc.	77 Warren Street, Brighton, MA 02135	Dr. Donald Lucas
Carville	National Hansen's Disease Center	Carville, La 70721	Dr. Robert R. Jacobson
New Orleans	New Orleans Home and Rehabilitation Center	612 Henry Clay Avenue, New Orleans, LA 70118	Dr. Robert Jacobson
Miami	Tropical Dermatology Clinic	1700 N. W. 10th Avenue, Miami, FL 33136	Dr. Francisco Ramos
Chicago	Division of Dermatology, Cook County Hospital	1835 W. Harrison St., Chicago, IL 60612	Dr. Sidney Barsky

Damien-Dutton Society history. The Society was founded by Howard E. Crouch in 1944, after his experience with a three-year tour of duty with the U.S. Army Medical Corps stationed on the island of Jamaica, West Indies, from 1941–1944. Mr. Crouch and his colleagues spent a great deal of time at the Spanish Town Leprosarium, a government-run institution with over 250 patients, staffed by a group of Marist Missionary Sisters from the United States. At that time there were no sulfones, and the main form of treatment was chaulmoogra oil. Patients were confined there for the most part of their lives. After Mr. Crouch's discharge from the U.S. Army, he formed a small band of workers to assist in the programs at Spanish Town, and it grew until at present it contains over 18,000 members in all 50 states and in 19 foreign countries. The main activity of the Damien-Dutton Society for Leprosy Aid, Inc., is fund raising and education. The Society assists several research laboratories in the United States and in Jerusalem. In addition, the Society aids over 25 different leprosy projects around the world including treatment, rehabilitation, and education. The Damien-Dutton Award is given each year to a person, persons, or organization making a significant contribution towards the conquest of leprosy. The Society also supports the INTERNATIONAL JOURNAL OF LEPROSY.—(*Adapted from* materials provided by Howard E. Crouch)

Dr. Roy E. Pfaltzgraff joins American Leprosy Missions. After 39 years as a leprologist in leprosy control programs in Gongola State, Nigeria, Dr. Roy E. Pfaltzgraff has accepted the position of Program and Training Consultant to the American Leprosy Missions. The last appointment held by Dr. Pfaltzgraff, Senior Specialist Leprologist in charge of leprosy control in Gongola State, is to be taken over by Dr. A. Jacob Navaneethan from Madras, India.

Leprosy cases reported in the United States in 1982. In 1982, there were a total of 231 leprosy cases reported in the United States according to the *Morbidity and Mortality Weekly Report* [**31** (1983) 702]. This compares with 253 cases reported in 1981 and a median figure of 178 cases over the years 1977–1981. Seventy-eight cases were reported from California, 44 from the Pacific Trust Territories, 37 from Hawaii, 31 from Texas, 29 from New York City, and 15 from the state of Washington.

President Ronald Reagan joins in observing World Leprosy Day. President Reagan issued the following communication on World Leprosy Day, 30 January 1983:

"Leprosy, or Hansen's disease, has long plagued the peoples of the world. For hundreds of years, the mystery and fear of this disease have caused the afflicted to be shunned, locked up, or exiled from society. Until recently, little was done to treat the disease or to understand it.

"Recent progress in drug therapy that can deactivate Hansen's disease has made it possible to treat most leprosy patients at home or on an out-patient basis. But superstitions and lack of general knowledge about the disease still cause untold problems for patients and their families. Despite medical progress, leprosy remains unchecked in many areas of the world.

"I call on all Americans to join with me in observing World Leprosy Day. Together, let us hope and pray that within our lifetime, through research and treatment as well as increased public awareness, we can eliminate the suffering caused by this heartbreaking disease. We must continue to assist and encourage the dedicated men and women throughout the world who are striving toward that end."

Waldemar F. Kirchheimer, M.D., Ph.D., retires. On 4 January 1983, Dr. Waldemar F. Kirchheimer, Chief of the Laboratory Research Branch, National Hansen's Disease Center, Carville, Louisiana, left to begin his retirement in Seattle, Washington. Dr. Kirchheimer was born in Schneidemuhl, Germany, and received his M.D. degree from Ludwigs University Medical Faculty in Giessen in 1937. He immigrated to the United States in 1938, and obtained his Ph.D. in microbiology from the University of Washington in Seattle in 1947. After a number of years in academia and on the staff at Fort Detrick, Maryland, Dr. Kir-

chheimer joined the U.S. Public Health Service in 1961 as a scientific administrator at the National Institute of Allergy and Infectious Diseases. The following year, 1962, he came to Carville as Chief of the Microbiology Research Section of the Laboratory Branch under Dr. George Fite. Although author or co-author of over 100 publications, Dr. Kirchheimer is perhaps best known as the author of the 1971 landmark publication with Dr. Eleanor Storrs describing disseminated leprosy in a nine-banded armadillo. This source of leprosy bacilli has been responsible for a vast number of advances in leprosy research since that time. Best wishes for a long and happy retirement go with Dr. and Mrs. Kirchheimer from his colleagues at Carville and around the world.—RCH

Zambia. *National Seminar on Leprosy Disability Prevention.* On 9–15 January 1983 the Ministry of Health in Zambia, with the assistance of their ILEP coordinator, The Leprosy Mission, held a seminar at the Mwachisompola Health Demonstration Zone. This was the first such meeting since 1978, when Dr. Stanley Browne and Miss P. Jane Neville visited Zambia. Those attending the 1983 seminar were provincial leprosy control officers, officers in charge of leprosy hospitals and physiotherapists, who made up a group of 33 workers representing government and mission institutions. The Permanent Secretary in the Ministry of Health, Dr. Joseph Kasonde, opened the meeting with a keynote address stressing the need to evaluate both the size of the problem and the resources available to deal with it. While accepting that the Ministry's goal was the eradication of leprosy from Zambia, this was a long-term aim and disability prevention must remain a priority until then. Sessions followed on health education in leprosy, and the role of the community health worker in leprosy control and disability prevention. Regular and appropriate assessment in combination with the introduction of multiple-drug treatment for all new cases had a large place in the future management of leprosy.

Most of the sessions were then led by Miss Jean Watson, Consultant Physiotherapist from The Leprosy Mission in London, who was making her fourth visit to Zambia. Her main points were that results had to be obtained from the rural health centers where assessment and follow up of patients took place. Results based on limited objectives, such as ulceration rate, had to be obtained, and questions had to be posed and answered if these targets were not achieved. Hospitalization time had to be maximally utilized, not just for the reason for admission, but also to teach self-reliance after discharge back home. The control officers had to be more fully aware of the potential of the 19 cobblers workshops in the country making footware for leprosy patients and make maximal use of them. Similarly the services of the physiotherapists in the hospital were not used to best effect, and these workers should be more involved in the leprosy control program.

The seminar was judged by all participants to have been most successful in achieving its two aims which were to focus attention on a major problem still causing great distress to many—that of disability due to leprosy—and also, equally important, in bringing together workers from different parts of Zambia, from Government and Mission, control workers and hospital workers, Zambians and expatriates. These informal sessions strengthened old bonds and forged new ones.—Dr. R. de Soldenhoff