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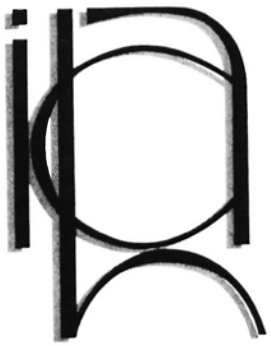
NEWS and NOTES

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.



The 13th International Leprosy Congress
11–17 September 1988
The Hague, The Netherlands

Message from the ILA President

The Thirteenth International Leprosy Congress of the International Leprosy Association, is likely to be a unique scientific event.

Leprosy today is at a turning point. Recent developments in immunology and molecular biology have opened new fields to study both the defense mechanisms of the host and the intimate structure of the leprosy bacillus, revealing new approaches to the possible development of a vaccine. Emergence of resistance in the bacilli has been met with new regimens of chemotherapy, creating different logistics and raising great challenges to program managers. The Primary Health Care approach calls for more community participation and integration into general health services. There is a renewal of concern for the leprosy patient and an urgent need to tackle social and community problems.

It is doubtful if any previous congress has ever generated such expectations for the control of leprosy.

The International Leprosy Association is particularly grateful to the ILA Congress 1988 Foundation from The Netherlands and to The Netherlands Leprosy Relief Association, a member of ILEP (the International Federation of Anti-Leprosy Associations), for having accepted responsibility for organizing this congress.

We hope that all those concerned with leprosy and leprosy patients from every part of the world will find this congress a great opportunity to learn about scientific advances and to renew their activities in the fight against this old, yet enduring disease.

Michel F. Lechat
President ILA

Tentative Time Schedule for 1988 Congress

Monday, 11 September	
09:00–10:00	Registration
10:00–13:00	Inauguration
	State of the Art Session
Lunch	
14:00–17:00	Congress Sessions (3)
Tuesday, 12 September	
09:00–10:00	State of the Art Session
10:00–13:00	Congress Sessions (3)
Lunch	
14:00–17:00	Free time
Wednesday, 13 September	
09:00–10:00	State of the Art Session
10:00–13:00	Congress Sessions (3)
	Poster Presentations (3)
Lunch	
14:00–17:00	Congress Sessions (3)
	Poster Presentations (3)
Thursday, 14 September	
09:00–10:00	State of the Art Session
10:00–13:00	Congress Sessions (3)
	Poster Presentations (3)
Lunch	
14:00–17:00	Congress Sessions (3)
	Poster Presentations (3)
Friday, 15 September	
09:00–10:00	State of the Art Session
10:00–13:00	Congress Sessions (3)
Lunch	
14:00–17:00	Congress Sessions (3)
Saturday, 16 September	
09:00–10:00	ILA Meeting
10:00–13:00	Closing Session

Twelve Congress subjects are planned: immunology, clinical aspects, experimental leprosy, microbiology, epidemiology and control, treatment, nerve damage, surgery and rehabilitation, ophthalmology, social aspects, experimental therapy, and pathology.

Special attention will be given to poster presentations, in connection with and completing the 12 Congress themes, in order to maximize the personal discussions and explanations of the research. The Organizing Committee will provide professional graphical assistance to participants for the preparation of their posters.

A one-hour "state of the art" session will be presented every morning during the Congress to cover recent progress in the main fields of research by five experts on immunological tools for leprosy control, recent developments in molecular biology, operational aspects of multidrug chemotherapy, nerve damage, and social aspects in primary health care.

Teaching and training sessions will be held continuously during the Congress. Video

films, continuous slide presentations and films will cover the subjects of immunology, pathology of early leprosy, reactive phenomena, epidemiology, case taking, information systems, deformity, disability assessment, vocational rehabilitation and health education. A question-and-answer period is planned following each presentation.

Congress workshops on immunology, epidemiology, chemotherapy, control, information systems, diagnosis and clinical aspects, training, prevention and management of impairment rehabilitation, vaccine trials, social aspects, and health education will be held the week preceding the Congress. Summaries will be made available by the end of the Congress.

The 13th ILA Congress will be held in The Netherlands Congress Centre, The Hague, The Netherlands, from 11–17 September 1988. Hotel accommodation will be provided in several price categories ranging from ca. Dfl. 50,- to Dfl. 250,- and more.

For information on fees and registration procedures, write:

Congress Bureau
QLT Convention Services
Keizersgracht 792, 1017 BC
Amsterdam, The Netherlands

or

Secretariat
Wibautstraat 135 NL-1097 DN
Amsterdam, The Netherlands.

China. *Research work on social medicine of leprosy.* On 11–12 June 1987, more than 20 experts in social medicine and leprology in China gathered at Nanjing to evaluate research work on social medicine of leprosy delivered by the Institute of Dermatology, Chinese Academy of Medical Sciences, and Nanjing Railway Medical College. Drs. Ye Gan-yun, Zhou Da-sheng, Shu Hui-wen, Jiang Cheng, and Bian Jing-guo presented their papers on the social, economic, nutritional, and psychological aspects of leprosy and leprosy control as surveyed in Bao Ying County. Dr. Ma Haide, adviser to the Ministry of Public Health, People's Republic of China, attended the meeting and expressed high appreciation of these papers. He suggested that a combination of knowledge of the social science and biological science of leprosy would be greatly beneficial to the government in planning leprosy control policy and achieving the goal of eradication of leprosy in China. These papers have been published in Chinese.—Ye Gan-yun

India. *Dr. Thangaraj and Mr. Askew retire.* According to a report published in the February 1987 issue of Karigiri Bulletin, Dr. R. H. Thangaraj, Director for Southern Asia of the Leprosy Mission, New Delhi, and Mr. A. D. Askew, International Director of the Leprosy Mission, London, have retired from service.

Dr. Thangaraj took over the Secretaryship of the Leprosy Mission, New Delhi, in 1978 from Dr. V. P. Das, the first Indian to hold the post under whose management the Mission's work was modernized, expanded and many referral centers established. During the tenure of Dr. Thangaraj, the post of Secretary was changed to Director. Prior to taking up the Secretaryship, he was Superintendent of the Philadelphia Leprosy Hospital, Salur.—(*From* Leprosy Review)

KLEP: Karigiri Leprosy Education Programme, South India. Three booklets have recently been produced by KLEP in South India: "Diagnosis and Clinical Manifestations of Leprosy," "Differential Diagnosis of Leprosy," and "Case Taking in Leprosy." These are each about 20 pages in length, paperbound, inexpensive in format but very clearly printed, and well illustrated with color pictures and diagrams. They have presumably been written and planned for work in South India, but they could be of value, not only in other parts of South East Asia, but in other leprosy-endemic countries. Contact: Schieffelin Leprosy Research and Training Centre, Karigiri 632106, South India.—(*From* Leprosy Review)

1987 National Awards for the Welfare of the Handicapped. The National Awards are presented to individuals and institutions for the best work done for the cause of the disabled, outstanding handicapped, self-employed workers, employees, and employers, and placement officers of the handicapped. The President of India Giani Zail Singh (left

in photo) presented Shri Uttam Nivrutti Shinde his award. Shinde is 42 and has suffered from Hansen's disease since the age of 26. One of Dr. Jal Mehta's patients, he was treated at the Dr. Bandorwala Leprosy Hospital, Pune. Due to ulcers, his right leg was amputated below the knee. He is now totally cured and carries on his normal activities with the help of an artificial leg. He is employed as a mixing operator, Laxmi Vishnu Mills, Sholapur. With dedication and hard work he has overcome his disability.—(*From* materials provided by Dr. Mehta)

Spain. *XI Ibero-Latin American Congress of Dermatology Leprosy Symposium.* A Leprosy Symposium of the XI Ibero-Latin American Congress of Dermatology was held in Madrid 17–21 May 1987. Chairmen were A. Saul (Mexico) and R. D. Azulay (Brazil); J. C. Gatti (Argentina), Coordinator; L. M. Olivares (Argentina), Secretary. Participants included: R. D. Azulay (Brazil); J. Barba Rubio (Mexico); W. Belda (Brazil); C. Bernardi (Brazil); J. E. Cardama (Argentina); C. Consigli (Argentina); R. Garrido Neves (Brazil); M. M. Giménez (h) (Argentina); J. Morini (Argentina); D. W. Opromolla (Brazil); Ma. F. Pacheco da Silva Mealha (Portugal); C. A. Pereira (Brazil); A. Saul (Mexico); J. M. Terencio de las Aguas (Spain); R. Waisman (Argentina).

The subjects, whose conclusions are listed below, were developed during the symposium:

I. Experimental leprosy. More than 10 years ago, experiments on tatus or armadillos were started both in Argentina and in Brazil. In the beginning, the species that were used did not belong to the genus *Dasypus.* Later on, these groups worked with animals of the *D. hybridus* and *D. novemcinctus* genus, and they achieved not only their adaptation but their reproduction in captivity as well. Inoculation with Shepard's technique resulted in a high percentage of animals with generalized leprosy.

In mice, inoculation of *Mycobacterium lepraemurium* in the CBi and CBA/j strains produced the spreading of the infection, resulting in 100% of lepromatous forms with the CBA/j strain and 38% of borderline forms with the CBi strain. In Brazil, BALB/c mice of the 12th generation have been recently inoculated with inocula from patients suspected of being sulfone resistant.

The experiments made to inoculate the European hedgehog failed.

II. Subclinical infection. Employing the Rivas Smith technique, the presence of acid-alcohol-resistant bacilli in peripheral blood has been demonstrated in tuberculoid and indeterminate patients (with negative bacilloscopy in skin and mucus) as well as in persons living with them who were clinically healthy. The search for bacillemia may be a useful indication of subclinical infection.

The joint use of FLA-ABS (fluorescein leprosy antibody absorption) and lepromin is also an interesting method for assessing subclinical infection. By means of combining these two assays we can get four possibilities: a) Lepromin+ and FLA-ABS+. Once infected with *M. leprae,* the development of a severe form is not probable, but the patient may or may not contract a minimal form of the disease. b) Lepromin+ and FLA-ABS−. The lepromin positivity may be the result of infection with other microorganisms that share antigens with *M. leprae* or it may be due to nonspecific factors (e.g., old age). c) Lepromin− and FLA-ABS+. Once infected with *M. leprae,* the individual may contract a severe form of the disease. It is the highest risk group, to which all the prevention measures must be directed, including vaccination. d) Lepromin− and FLA-ABS−. Not infected with *M. leprae* nor with other microorganisms that share antigens with it. If the individual

has clearly been in contact with leprosy, he may pertain to the group with a low immunologic response, that is to say, that although they are negative they may be infected, in which case they might develop a lepromatous form.

As regards serology for leprosy, it was shown that enzymoimmunoassay (ELISA) is easier to perform and has a lower economic cost than FLA-ABS. However, the results obtained with this technique are less specific than those obtained with FLA-ABS. It is indispensable to effect the previous absorption of sera with other mycobacteria (BCG, *M. vaccae*).

III. Factors affecting the immunologic response. As regards the microorganism's own factors, although the antigenic structure of the bacillus is not completely known, components of crossed reaction with other mycobacteria have been identified (surface antigen 7, equivalent to the antigen 60 of BCG) as well as specific species components (glycoproteins with molecular weight 33,000 and 12,000).

Recently, lipid antigens with biological activity, chemically related to the phenolic mycoside A, have been detected in the tissues of infected armadillos. This phenolic glycolipid could serve as a sign of subclinical infection, since 80% of the patients suffering from leprosy have antibodies against it.

As regards the role of the macrophages, it cannot yet be stated whether their defect (non-lysogenic macrophages) is primary or secondary. Experiments carried out in lepromatous patients, inoculating lepromin plus BCG, have shown that in the presence of BCG the macrophage can turn its condition to lysogenic macrophage, that is to say, that other factors besides the genetic are probably involved. *In vitro* experiments have shown that the addition of interleukin 2 (IL-2) can improve or recover the lysogenic capacity of the macrophage.

As regards wild leprosy, one case has been found in Argentina (Corrientes province) in one armadillo, confirmed with inoculation tests in other armadillos.

IV. Cellular markers. Enzyme identification (lysozyme and α1 antichymotrypsin) using the immunoperoxidase technique is useful as cellular markers of the macrophage line, epithelioid cell, and giant cells. These techniques can be applied to the classification of the dimorphous leprosy subgroups.

V. Langerhans' cell in leprosy. The study of the Langerhans' cell in patients suffering from leprosy, using the ATPase histochemistry technique in epidermal lamina and the OKT6 monoclonal marker as a control, has shown a remarkable decrease in the amount of said cells in lepromatous leprosy, both in lesional and in healthy skin. While in tuberculoid leprosy there has been found an increase of the Langerhans' cells in the epidermis in lesional skin, a sign of the increase in cell-mediated response; there were no significant differences in the general population in indeterminate leprosy and in borderline leprosy; on lesional skin, higher levels than those found in the healthy controls were assessed. It has to be clarified whether this alteration of the Langerhans' cell is a primary or secondary phenomenon.

VI. Bacterial resistance-persistence. In the Ibero-Latin American countries, the bacterial resistance degree rated from the clinical point of view varies from 5% to 8%. The incidence of resistance decreases when polychemotherapy is used. About 12 strains of *M. leprae* have been identified that are resistant to 2 drugs: 11 strains resistant to diaminodiphenylsulfone (DDS) and rifampin (RMP) and 1 strain resistant to DDS and clofazimine. It has also been proved that resistance to RMP appears faster than to DDS and that the RMP-resistant strains are susceptible to clofazimine, whereas those strains resistant to clofazimine can also be RMP resistant.

It could be possible even for the tuberculoid patients to develop a primary resistance.

As regards the bacilloscopies of the back of the fingers, experiences show that there are no differences between the active and inactive multibacillary patients, with regard to other places (auricular lobule).

A useful resource to detect and discard one of the most important resistance causes is the assessment of sulfonuria in ambulatory patients. According to the experiments done, 6% of the tested patients presented doubtful sulfonurias and received thalidomide. It is possible that thalidomide interferes with the absorption mechanisms of sulfone. It is necessary to correlate those results with the sulfonemia assessment.

While bacterial resistance is the result of a genetic mutation, persistence is due to an adaptation process of the microorganism

which, under adverse conditions, reduces its vital requirements, acquiring the capacity of remaining in lethargy, that is to say, it is a phenomenon based on metabolic changes.

VII. Therapeutic patterns. The multidrug patterns (2 or 3 drugs) are applied in all the Ibero-Latin American countries. Most of the work groups maintain RMP for periods not shorter than 6 months. However, in those countries, the pattern proposed by the WHO (multidrug supervised treatment) has been used in general as pilot experiences.

Opinions regarding the convenience of said pattern are controversial. Its application could favor the development of antirifampin antibodies (risk of interstitial nephritis with acute renal insufficiency) and the appearance of resistance to RMP. A faster bacilloscopic negativization and a clinical improvement are achieved with the daily doses of RMP. We insist on the care that has to be taken when employing therapeutic patterns with doses that are not recognizably efficient, because since they involve the risk of developing resistances, the leprosy patient becomes an experimental subject.

There are several promising new antibacterial drugs: the first generation quinolones (ciprofloxacin and pefloxacin) and the second generation quinolones (ofloxacin). These drugs have a longer life, and their concentration increases in the inflammatory foci. Ofloxacin (Oflocet®) is given in doses of 400 to 800 mg/day. Hypersensitivity phenomena are mentioned.

The ansamycins derived from rifampins include: LM 427 (10 times as active as RMP), rifapentine or rifamycin S or DL 473 and rifabutine or R 76-1 (10 times as active as RMP).

The compounds inhibiting enzymes of the folate chains and the new derivatives of sulfone (prolonged liberation products) are also mentioned. All of them are now at an experimental level, therefore it is advised to continue the studies with them.

VIII. Genetics and leprosy. The work undertaken by IMMLEP (a cooperative group including 11 countries) showed that although susceptibility to leprosy is not coded by HLA factors, once the disease is caught, the clinical form it will develop depends on these HLA factors. We can correlate tuberculoid leprosy to HLA DR3 and the negative lepromin reaction to HLA-MB1.

On the other hand, the lepromin reaction has been studied in families of cohabitants and in healthy families, and a positive and significant correlation has been found between the size of the Mitsuda reaction in the parents and in their respective children. That is to say, the genetic component of said reaction could be handled as a qualitative hereditary character (positive or negative) due to the action of very few genes or as a quantitative hereditary character (variations in the magnitude of the reaction) due to the action of an additive polygenic system.

In Argentina, we are working on genetic engineering to diagnose mycobacteria by means of molecular probes. The first results led to obtaining a specific probe for *M. bovis*. The future finding of a specific probe for the identification of *M. leprae* will open the road for the search of subclinical cases, incubation period, environment, possible vectors and reservoirs.

IX. Immunotherapy and immunoprophylaxis. In Brazil, the use of the vaccine proposed by Convit (*M. leprae* + BCG) was started in a small group of lepromatous patients in active sulfone-resistant patients and clinically healed patients. Specific medication is not interrupted and the vaccine is given every 3 months.

Another Brazilian group, using said vaccine, has demonstrated the conversion of the non-lysogenic macrophages into lysogenic macrophages.

At an experimental level, the use of BCG or the ICRC bacillus (strains C44 and C75) both on BALB/c mice and on monkeys has achieved the conversion of the lepromin reaction.

Undoubtedly, the future of immunotherapy lies in genetic engineering, with the second generation vaccines, and all the research efforts must tend to that aim.

Future subjects include: experimental leprosy; serology in leprosy (ELISA-FLA-ABS); immunologic role of the antigen-presenting cells (macrophages, Langerhans' cells, monocytes); enzymatic immunohistochemistry (cellular markers); genetic engineering; vaccine; new antileprosy drugs.—Prof. Dr. J. C. Gatti

U.K. *ILEP Catalogue on Training, 1987.* We are grateful to the General Secretary of ILEP in London for permission to publish the following list. Address all enquiries to the "contact" of the relevant centre.

ALERT: (All Africa Leprosy and Rehabilitation Training Centre) (WHO Collaborating Centre for Training in Leprosy), PO Box 165, Addis Ababa, Ethiopia.

Contact, Director of Training. Telephone, 201200-201201-201524. Telegrams/Telex, ALERT ADDISABABA/21312 GLRA ET. Nearest Airport, Addis Ababa. Accommodation, Hostel: maximum 28 people. (Cost: US$ 10 per day). Language, English. Recognition of courses, by WHO and Government.

BAMAKO: Institut Marchoux, BP 251, Djikoroni, Bamako, Mali.

Telephone, 22.51.31. Contact, Dr M Nebout, Directeur, Dr B Grossetête, Chef Unité Enseignement. Aeroport, Bamako. Logement, Internat. Bourses d'Etudes, Octroyées soit par les gouvernements des élèves, soit par les différents organismes comme l'OMS et les Associations-membres de l'ILEP, dont l'Association Française Raoul Follereau. Les demandes de bourse auprès de ces organismes doivent être présentées au Secrétaire général de l'OCCGE (Organisation de Coordination et de Coopération pour la lutte contre les Grandes Endémies, B.P. 153, Bobo-Dioulasso, Haute-Volta). Langue, Français.

BAURU: Hôpital Lauro de Souza Lima, Rodovia Cte. Joao Ribeiro de Barros, Km 115, Caixa Postal 62, CEP 17.100, Bauru, Sao Paulo, Brésil.

Telephone (0142) 23.59.22. Contact, Dr Diltor V A Opromolla. Langue, Portugais.

CARACAS: Instituto de Biomedicine, Apartado Postal 4043, Caracas 1010A, Venezuela.

Contact, Dr Jacinto Convit, Director. Airport, Caracas. Language, English. Recognition of courses, WHO, CEPIALET.

CARVILLE: Gillis W Long National Hansen's Disease Center, United States Public Health Service Hospital, Carville, LA 70721, USA.

Telephone (504) 642.77.71. Contact, H Austin Hayes, Director of Education and Training. Nearest airport, Ryan Airport, Baton Rouge, LA. Accommodation available. Language, English. Recognition of courses, By Government, and American Medical Association.

CEBU: Leonard Wood Memorial Center for Leprosy Research, PO Box 727, Cebu, Philippines.

Telephone (32) 827.46. Telegrams, WOODMEM CEBU. Contact, Director. Nearest airport, Cebu. Language, English. Recognition of courses, WHO, Government.

DAKAR: Institut de Léprologie Appliquée de Dakar (ILAD), BP 11023 CD Annexe, Dakar, Sénégal.

Telephone, 22.36.15. Contacts, Dr J Millan, Directeur ILAD and Dr J C Naudin, DAHW-SENEGAL. Aeroport, Dakar-Yoff. Logement, A l'ILAD: 8 chambres individuelles (pas de repas, mais facilités proches), En ville: logement en hôtel aux frais des intéressés.

Frais d'inscription, Seulement pour le certificat de Léprologie de l'Université de Dakar 50,000 francs CFA. Les autres cours et stages sont gratuits grâce au soutien financier de Amici di Raoul Follereau, et de l'Ordre de Malte. Bourses d'Etude, L'Institut ne prenant en charge ni le voyage ni les frais de séjour des stagiaires, ceux-ci peuvent solliciter des bourses d'étude auprès de leur gouvernement, de l'Ordre de Malte, de l'OMS ou d'une Association-membre de l'ILEP. Langue, Français. Reconnaissance des cours, Le Certificat de Léprologie est délivré par la faculté de Médecine de Dakar. Responsables, Directeur de l'ILAD, Responsable médical DAHW.

FONTILLES: Sanatorio de San Francisco de Borja, Fontilles (Alicante), Espagne.

Telephone (965) 58.33.50. Contact, Dr José Terencio de las Aguas, Médico Director. Aeroports, Valencia et Alicante. Logement, Disponible dans le centre. Langues, Espagnol et français. Reconnaissance des cours, Par la Direction Générale de la Santé, par l'Ecole Professionnelle de Dermatologie, et par l'Ordre de Malte. Bourses d'Etude, Octroyées par l'Ordre de Malte.

KARIGIRI: Schieffelin Leprosy Research and Training Centre, Karigiri, SLR Sanatorium PO, PIN 632 106, North Arcot District, South India.

Telephone, Vellore 21522 with extension to Director/Deputy Director in Administration, Deputy Director of Training—SAX Karigiri No. 25, Training Unit—SAX Karigiri No. 37. Telegram, LEPSEARCH VELLORE 7. Contact, Training Officer. Nearest airport, Madras. Nearest rail station, Katpadi. Accommodation, Guest House: 30 persons (limited single rooms sometimes available). Hostel: Men—60 persons. Women—16 persons. Language, English. Recognition of courses, In-service training courses in reconstructive surgery, pathology, leprosy control, medical aspects, are recognized by WHO and Indian Government. All paramedical and technical courses are fully recognized by Indian Government.

MEXICO: Centro Dermatologico Pascua, Dr Vertiz, 464 Esq Av Central, Delegacion Cuauhtémac, CP 06780, México DF, México.

Telephone: 538-70-33 ou 519-63-51. Contact, Dra Obdulia Rodriguez, Directora. Aeroport, México. Logement, Hôtels. Language: Espagnol.

YAOUNDE: Centre d'Enseignement et de Documentation de l'OCEAC (Organisation de Coordination pour la lutte contre les Endémies en Afrique Centrale), BP 288, Yaoundé, Cameroun.

Telephone, 23.22.32 (Secrétaire général), 23.00.61 (Centre d'Enseignement et de Documentation). Contact, Dr D Kouka Bemba, Secrétaire général, Dr L Sentilhes, Secrétaire général honoraire, Dr R Josseran, Chef du Centre d'Enseignement et de Documentation, Dr P Ambassa (Adjoint au Chef du Centre d'Enseignement). Aeroport, Yaoundé. Langue, Français.—(*From* Leprosy Review)

New Director for LEPRA. LEPRA, the British Leprosy Relief Association, has appointed a new Director: Mr. Neil Winship. Mr. Winship, a Natural Sciences graduate, served 22 years in the Royal Tank Regiment before leaving to help with famine relief efforts in the Sudan. Mr. Winship, who first came face to face with leprosy in the course of his widely traveled army career, commented: ". . . Having witnessed the effects of leprosy at first-hand in southern Sudan and elsewhere, I wholeheartedly support efforts towards its eradication."

When he left the army in 1985, critical conditions in the Sahel prompted him to volunteer to help Band Aid with their Sudan trucking. Six months later he became Logistics Manager for the international relief charity, World Vision, working in the central Sudan. He soon became involved, however, in the task of getting emergency food supplies through to the Churches' Relief Committee in the southern Sudanese town of Wau, which at that time was surrounded by rebel troops. He returned to England in March of this year and is now working alongside Mr. Francis Harris, LEPRA's Director since 1962, before formally taking up his post on 1 January 1988.

"Clearly it is vital that I gain a sound, if layman's understanding of leprosy; its enigmatic nature, the treatment, and hopes for prevention," said Mr. Winship. "While a passing but rusty knowledge of organic chemistry, and a familiarity with microscopy should help a bit, far more significantly my scientific background has helped me appreciate the scope and complexity of the leprosy clinical and research fields."

Mr. Winship traveled to Malawi in October 1987 to observe the large-scale epidemiological survey and vaccine trial, as well as the treatment programs that LEPRA is carrying out there. "This is our flagship project," he said, "and my visit will be an essential as well as stimulating part of my in-

duction. However, what has already become clear to me during my short time with LEPRA is the challenge in extending our activities in cooperation with host governments to make multidrug therapy available to a greater number of sufferers worldwide."—(*From* LEPRA press release)

Teaching video on chemotherapy of leprosy available. Dr. Colin McDougall of The Slade Hospital, Oxford, has produced a teaching video which describes the recent regimens of drug treatment of leprosy based on the report of a World Health Organization Study Group entitled "Chemotherapy of Leprosy for Control Programmes" (WHO Technical Report Series No. 675, 1982). The video covers the classification of leprosy according to both Madrid and Ridley-Jopling systems; definition of paucibacillary (PB) and multibacillary (MB) leprosy; unit dosage and regimens of dapsone, rifampin, clofazimine, and the thioamides for the treatment of both PB and MB leprosy cases. Repeated emphasis is given to the importance of the training, retraining and supervision of the health personnel.

The intended audience includes medical students, medically qualified doctors, senior personnel in ministries of health in leprosy-endemic countries, tutors and teachers in medical and paramedical schools, program planners, leprosy control officers and supervisors, and senior staff in pharmacies, drug supply and distribution.

The video is in English, runs 14 minutes, is in the VHS PAL 625 format, and costs £16 (US$25) which includes postage and packaging. Contact: Department of Medical Illustration, John Radcliffe Hospital, Headington, Oxford OX3 9DU, England.

U.S.A. *1987 Molecular Parasitology Awards announced.* Richard A. Young, Ph.D., Assistant Professor of Biology at the Massachusetts Institute of Technology and an Associate Member at the Whitehead Institute for Biomedical Research, has been named the Burroughs Wellcome Scholar in Molecular Parasitology for 1987.

The $250,000 Molecular Parasitology Scholar Award is given annually by The Burroughs Wellcome Fund to recognize the pioneering contributions of Sir Henry Wellcome to the study of tropical medicine. An important goal of the program is to support the application of modern developments in biology and chemistry to the understanding, control, and prevention of parasitic diseases.

Dr. Young received a B.S. in biological sciences from Indiana University in 1975, earned a Ph.D. degree in molecular biophysics and biochemistry from Yale University in 1979, and did postdoctoral research at the Swiss Institute for Experimental Cancer Research and at Stanford University. He joined the Whitehead Institute and MIT in 1984.

Since 1983 Dr. Young has served on advisory panels for the Special Program for Research and Training in Tropical Diseases sponsored jointly by the World Health Organization, the World Bank, and the United Nations. He has been a member of the steering committee for the Program for Immunology of Leprosy, and is currently chairman of the Special Program's Subcommittee on Molecular Biology.—(*From* The Burroughs Wellcome Fund news release)

U.S.S.R. *Academy of Medical Sciences.* In May 1986, a regular Plenary Session of the Scientific Council on Dermatology and Venereology of the Academy of Medical Sciences of the U.S.S.R. was held in Kaunas (Lithuania). Among the materials of the session, the theses of the following papers on leprosy appeared:

Abdirov, C. A., Vdovina, N. A. and Nazhymov, B. N. Epidemiological aspects of leprosy in children and teenagers.

Baranov, Y. N., Sukhenko, L. T. and Saroyants, L. V. The role of genetic factors in immune response in leprosy.

Dyachina, M. N., Vorobjova, Z. G., Sukhenko, L. T. and Juscenko, A. A. Immunodiagnosis of leprosy.

Juscenko, A. A., Kogan, V. R. and Kadantsev, N. D. On leprosy control measures in the U.S.S.R. in modern stage.

Naumov, V. Z. and Balybin, E. S. A system of hypophysis-adrenal cortex and lymphocyte functions in lepromatous leprosy.

Urlyapova, N. G. Experimental assessment of antileprosy activity of some derivatives of polychlorocarbonic acid.—A. A. Juscenko