

**WORKSHOP 12: REHABILITATION***Chair:* M. Brand\**Rapporteur:* S. Solomon*Participants*

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**Introduction.** Any leprosy program which fails to address the patient's disability and dislocation from society is, from his or her perspective, a failure.

**Definition.** Rehabilitation is the process of maintaining or restoring the individual to his or her rightful place in society.

**Objectives.** Rehabilitation may be implemented by the achievement of the following objectives: a) Encourage early treatment of the disease, and perseverance until cure, thus preventing many of the common nerve and ophthalmic complications; b) establish programs to monitor patients for early signs of nerve or eye involvement and apply appropriate measures to minimize damage; c) develop reconstructive surgery and ophthalmology programs including the provision of specialist training in these fields; d) find (or create) job opportunities for the individual appropriate to his/her ability. This may involve vocational or other training, and encouragement toward achieving independence and the ability to compete for employment in the community; and e) for the severely disabled, make life possible with dignity and fellowship, regardless of their physical condition.

**Specific recommendations.** While many aspects of rehabilitation have been addressed previously and by other workshops, this group would emphasize the following points:

**Disability control:** It is the responsibility of staff at all levels, peripheral, regional and central, to a) set measurable objectives for disability control and rehabilitation, and evaluate their progress toward them, and b)

teach and enable patients to minimize their own disability problems.

Patients and families are often even more motivated than paramedical workers and may be quick to learn simple techniques of testing and follow-up, and preventive care. They must be used.

**Disability recording:** The World Health Organization system for grading disability is for statistical purposes and is not intended for recording the status and progress of individual patients. Detailed records are necessary to monitor changes in eye and nerve status. However, these will be too complicated for routine assessments. Hence, it is essential that there be, in addition, a simple disability record for field use. From it changes in eye status, in sensation and strength, and secondary problems may be immediately identified and appropriate action taken on a priority basis.

**Implications of multidrug therapy (MDT):** Concern was expressed about a possible increased risk of early nerve damage to "borderline" disease patients on MDT. Only time and careful record keeping will confirm or rule out this concern. Therefore, it is important that: a) field personnel at the peripheral level be trained in the recognition and recording of eye or nerve damage; b) field personnel be able to refer patient or initiate appropriate treatment to prevent damage/deterioration (patient confidence and compliance may otherwise be jeopardized); and c) intensive surveillance must continue even after the completion of MDT in the patient.

Care must also be taken to be aware of nerve damage in patients with "silent neuritis."

\* Substituting for Dr. E. P. Fritschi.

**Surgery**

For nerve involvement: In the management of neuritis, when medical treatment alone has proved ineffective, a timely nerve decompression may not only relieve pain but improve the prognosis for functional recovery. Further complications, such as plantar ulceration, may thus be avoided. The procedure must be done before the nerve is irreversibly damaged. It may be done by any surgeon with appropriate training.

Reconstructive surgery: Surgery in patients with established paralysis is not of an emergency nature. As long as proper care is taken to prevent the development of secondary deformity, such surgery may be delayed until a competent surgeon is available.

Eyelid surgery: Patients who have lagophthalmos are at risk of corneal damage. If corneal sensation is impaired the risk becomes critical. Some type of tarsorrhaphy should be done as soon as possible. If corneal sensation is carefully evaluated and found to be intact, a temporalis fascio-muscle transfer may be done. It offers a better cosmetic effect, but it also calls for more experienced surgical personnel. If corneal ulceration is present secondary to exposure (due either to lagophthalmos or corneal insensitivity or both), a temporary tarsorrhaphy by a mattress suture to close the lids should be done as an emergency procedure

combined with standard antibiotic and other therapy. Facilities and trained personnel should be available at the field level in all control programs.

Intraocular surgery: Patients having impaired corneal sensation or a history of iritis are at risk for serious postoperative complications following intraocular procedures, such as cataract extraction. They should be referred for such to a skilled ophthalmic surgeon experienced in ocular leprosy.

Ulcer and foot care: Ulcers of anesthetic feet may often be prevented by daily care, inspection for any signs of early damage, and the regular use of appropriate footwear. The patient must be trained and encouraged to take this responsibility. Ulcers, once they have occurred, need rest. In uncomplicated cases, bed rest is not mandatory; some simple ulcers may be managed by the wearing of protective footwear and limiting walking to the minimum; others will need the use of established procedures for ulcer healing. This Workshop emphasizes that the provision of footwear and other disability prevention measures must be an integral part of any control program.

**Conclusion.** Rehabilitation is not an additional option for leprosy control that may be left out if funds are limited. It is fundamental to the success of our programs which may be a waste of money without it.