Community dermatology inclusive of leprosy: its past present and future

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Summary  The archives of leprosy and its global history are currently evolving in Oxford. A collection of documents and books are housed in the historical library of Sir William Osler under the heading of ‘Public Health before and after Osler’ and the history of leprosy can be found on http://www.leprosyhistory.org. A striking feature of the old books is their attention to the designation ‘Lepra’ and the evolution of not just leprosy but of the other differential diagnoses of the eighteenth and nineteenth century such as psoriasis. Even in the twentieth century, the development of a major interest in Oxford led by Weddell was the innervation of the skin first in psoriasis and then in leprosy, joint meetings with Weddell, Cochrane, Browne, Rees and others over patients with leprosy, to the building of the Cochrane Annex and the work of Colin MacDougal in the Department of Dermatology.

At an ILEP workshop in 1997, one conclusion was that dermatology might provide a solution to the sustainability of leprosy related activities. Dermatology has recently been redefined by one of the Governing bodies of the International League of Dermatological Societies. (www.ilds.org). It is a definition that emphasizes the urban based private practice orientation of dermatology, which though it is one of the lesser routes into care for the patient affected by leprosy, nevertheless is the one in which the taking of a biopsy is routine. There is, however, an increasingly significant branch of dermatology falling into the company of those in public health. It is called community dermatology. There are many examples of the way it is currently providing leadership for the management of leprosy in the future. It focuses on strengthening the general health services, it works on integration with other systems of medicine, and it collaborates with and forms teams as a matter of policy. It is concerned with strengthening diagnosis, low cost management of diseases that stigmatize and ruin life by causing the skin to fail.

Improving the functions of the skin to help it to be displayed with confidence and to act as a barrier in an increasingly threatening environment is exemplified by leprosy. There is concern for leprosy as a prototype of disfiguring disease.

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The past

The global history of leprosy is being recorded (http://www.leprosyhistory.org) and some of the archives are stored in Oxford. The chosen site for storage of the Oxford archives is 13 Norhams Gardens, the home of the Regius Professor of Medicine, Sir William Osler, from 1905 to 1919. His great library is housed in Montreal, but the main room of his Oxford house is now the centre for an ‘Archive of Public Health Before and After Osler’. The leprosy archive includes many nineteenth century books related to leprosy, and the pictures illustrate that this was an era in which leprosy diagnosis evolved with dermatology, but that there was confusion with other skin diseases. Dermatology has never lost its interest and most major textbooks have had, and still have, substantial chapters on leprosy. There are many dermatologists who have worked in this field who have sometimes adopted the name ‘leprologist’ and lost their dermatological identity. Some countries such as India keep leprosy to the fore in their association/society and journal terminology, viz. The Indian Association of Dermatologists, Venereologists and Leprologists. The contemporary Regional Dermatology Training Centre for Africa based in Tanzania is a WHO Collaborating Centre for Dermatology, Sexually Transmitted Infections and Leprosy.1–3

The archives on leprosy in Oxford document the frequent discussions over patients housed in the Dermatology Department at group meetings attended 40 years ago by Cochrane, Browne, Rees, Vollum, Jamieson, Vickers and Ryan. Even a few weeks before the death of Colin MacDougall, in February 2006, he was visited by dermatologists who worked alongside him 20 years ago, and whose enthusiasm for leprosy is undiminished. They continue to do basic research into one of the main interests of Colin and the department, ‘why does vascular endothelium, both blood and lymphatic, act as a site for apparent multiplication of M. leprae and can it be made to be so in vitro?’

The present

Dermatologists have watched the gradual development of today’s confusing scenario in the field of leprosy. They have collaborated and have been part of the era of MDT and taken part in discussions as the vertical programme was rightly disbanded. There is some disappointment in how taking leprosy into the general health services has evolved. In 1996, ILEP called a meeting about the sustainability of a service and concluded ‘the dermatology approach may be appropriate.’4 Leprosy Governance has not helped dermatology nor collaborated to strengthen general health services. Rather, it has presented to these already overloaded services its rather heavy package in the expectation that they will not simply shelve it, but would possibly make the services more patient friendly.

This has resulted in a complex debate along the following lines with a 40-year history. In 1959, the International Society of Tropical, Ecologic and Geographic Dermatology was formed so that Dermatology could make a greater contribution, beyond that to the developed world (www.intosocdermatol.org). During the Presidency of Terence Ryan beginning in 1990, its title was simplified to The International Society of Dermatology. The journal of the society and its twice yearly meetings and 5-yearly International Congress have always given ample space to leprosy.

The Regional Dermatology Training Centre in Tanzania (RDTC) was set up to cater for Sub-Saharan Africa, as it had no sustained advice on dermatology to governments,
universities, hospitals or rural health centres. Its 2-year course for Allied Health Professionals has provided 150 ‘dermatologists’ for Africa, several of whom are heading leprosy programmes. The RDTC has from its beginning been directed by Henning Grossmann, a one-time leprosy programme director, and many committed and eminent teachers in the field of leprosy.

A somewhat different focus has been given to a programme in Mali, being a 1-day course for all health centre personnel on common skin diseases. The effect of this programme on knowledge of leprosy is described by Faye et al. in this Special Issue of Leprosy Review.

The International League of Dermatological Societies (ILDS) has a very selective award system of issuing certificates of appreciation for outstanding contributions to Dermatology; several of these have been given to ‘leprologists’, most recently in 2006/2007 to Dr Pierre ’Bobin, Dr Joy Schultz and Dr Ben Naafs.

Other areas which have relevance for patients with leprosy and where British dermatology has taken the lead include creation of the International Skin Care Nursing Group (ISCNG), affiliated to the International Council of Nursing, to provide outreach nursing, evidence based and integrated medicine for lymphatic filariasis,5,6 promotion of research and coordination in wound healing and promotion of self help for chronic wounds and, where appropriate, to integrate with other systems of medicine.7

The ILDS documents make it clear that the dermatology profession is expected to support and even lead community dermatology. The field of leprosy must understand the potency of this public health orientated movement within dermatology.

The future

One must accept that there are several routes into care of the leprosy patient in India, which includes the government doctor, significant but still not tapped private sector, huge sector of Indian systems of medicine and the voluntary sector of non-government organizations (NGOs) providing host of services.8

When concern for the management of the destitute is discussed, much has been written about how to integrate the person affected by leprosy into society. Leprosy organizations when taking this issue into general health services focus the instructions on leprosy alone. At the RDTC in Tanzania, occupational therapy training is followed by further training specific for leprosy at ALERT, which is then generalized and aimed at income generation for all those disabled. A weekly timetable would include identifying those in need of shoes for a wide range of reasons, such as leprosy, lymphatic filariasis and road accidents, discussing with the albino programme the training of those affected by albinism to set up workshops to make shoes or other aids. The Operating Schedule includes in its weekly programme identification of those needing surgery for foot drop or neuropathies due to leprosy, diabetes or trauma.

The aim is to strengthen general health services to cope at low cost with all that requires a skin diagnosis9 and management in countries where poverty and HIV/AIDS cannot allow focus on leprosy alone, but where control of common skin disorders ultimately allows those with leprosy also to benefit.
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