

## LEPROSY TREATMENT IN PRIVATE PRACTICE

### EDITORIAL

The introduction of multidrug therapy (MDT) as recommended by WHO in 1981 caused important modifications in the treatment of leprosy such as the awareness of patients of a limited period of drug intake and a more objective concept of cure.

In February 1992 more than 2 million patients were released from treatment and the prevalence of leprosy has been decreased in most endemic countries with a reduction of 42% of registered cases between 1985 and 1992.

However, the introduction of MDT in Brazil was not troubleless and only in 1986 these regimens were adopted more regularly.

Initially, coordinators of control programs preferred a slow and stepwise implementation of MDT, particularly in study areas where evaluation of its operational and clinical aspect could be undertake. Afterwards, MDT was introduced in all areas with adequate conditions for its implementation and in 1991 the Ministry of Health officially recommended MDT as the choice treatment of leprosy nationwide. Presently, coverage of MDT in Brazil do not exceed 40% of registered cases. However, the implementation has proceed in a continuous and steady way. For example, in São Paulo State, one of the last regions to introduce MDT, almost all districts have already introduced MDT.

However, the acceptance of MDT has not been easy throughout the country. Many doctors and professors in medical schools still do not agree with the use of rifampicin once monthly or even that treatment could be discontinued after 6 month for PB cases still showing slightly active lesions. Moreover, is inadmissible to them to discontinue drugs in MB cases after only 2 years of treatment as recommended by WHO, although many countries has been doing this for

several years.

Among these professional, most of them treat their cases in their own private clinics. To one side, this is a very positive fact, since patients which can afford for private treatment may choose his/her doctor. However, it is important to point that these patients should have an integral approach of treatment. They should be examined thoroughly, undergo Lepromin test and other related analysis and a copy of the basic medical record should be send to the Health Unit in charge of the control programs. Drugs may be bought in pharmacies or collected free in the Health Unit. It is also very important that these private doctors demand the examination of contacts by himself or refer them to the Health Unit. Follow-up of each case should also be reported and at the time of released from treatments, doctors should notify the control program for epidemiological procedures.

Unfortunately, this is not what usually happens. Many doctors avoid the epidemiological side of leprosy and do not care for contact examination, which is precious for early diagnosis and simple to treat. They do not care for maintaining a productive relationship with the health authorities to achieve in the long run the eradication of leprosy. They omit information and do not offer to patients all the range of actions, such as prevention of disabilities and health education.

From the therapeutic point of view, the worst fact is that some of these doctors do not accept the proposed regimens and introduce modification that leads to many problems. This is the case of new drugs with anti-leprosy activity such as fluorquinolones. Partially informed on the possibilities of its use in leprosy, these doctors use such drugs without any basic caution, mainly those regarding its use as monotherapy.

The final result is a patient irregularly

treated, not confident in his/her cure and a breakdown in the control programs. Moreover, when such doctors are professor in medical schools, their opinion can hazardously influence a great

number of new doctors and than the negative impact over the action to control leprosy is multiplied.

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