

HANSEN'S DISEASE AFTER CURE

Editorial

It was a very important decision the WHO recommendation for the use of MDT in all countries where Hansen's disease is endemic.

In spite of some constraints as to the strategy for the implementation of the new therapeutic regimens they became very useful.

The most important part of this recommendation may be the courage to declare a Hansen's disease patient cured. It is true that many patients were also cured with sulphone but they were never declared cured because some of them relapsed after they have stopped the treatment and the leprosy workers became afraid that this could happen with the others. On the other hand it is important to sign that it was never made a campaign with the sulphone as it is being made with MDT, in spite of it is known that in places where dapsona was given regularly the therapeutic results were very good.

The introduction of the MDT was due mainly to the emphasis given to the appearance of bacilli resistant to sulphone and to rifampicin, a fact that was observed in many countries. This happened in 1981 in spite of association of drugs to treat Hansen's disease and to avoid the appearance of drug resistance has been proposed in early 1963.

Being it this way or the other, the new regimens came and the big problem today is the transformation of Hansen's disease from an infectious disease to an immunological one. Because of this what many patients suffered when they have begun the treatment they continue to suffer after they are declared cured. This is a difficult problem to explain to the patients, their families, and even to the health staff, because if the disease is cured why after the cure it continues to happen as before ?

The number of patients that continue showing immunological manifestations after the cure is not the case because the epidemiologists, and bacteriologists already know that these patients will not become an important problem to

the leprosy elimination in the world in the year 2000. What is of interest now is to define how these patients should be treated.

When type I reaction occurs without a severe neural involvement, there is no need of treatment save that the acute episode is serious. In the latter we must use the corticosteroids, but it is important to remember that the drug must be given for a long time, because this type of reaction takes 4 to 6 months to disappear spontaneously, and the steroids do not shorten this period.

As to ENH (type 2 reaction), these reactional episodes are treated according to their intensity, when they do not have neuritis, ocular reactions or reactional hand. The mild reactions may be treated with non hormonal anti-inflammatory, analgesic and antipyretic drugs, and the others with thalidomide save if the reaction is very severe.

When thalidomide could not be given and in the severe reactional episodes the only drugs available are the steroids. It is important to call the attention to the necrotic ENH in which even the corticotherapy may be inefficient and the patients need to be referred to a hospital for water and electrolytes reposition, and to be given proteins and antibiotics to overcome infections. The steroids are then the only therapeutic resource to treat some reactional cases mainly those with neural involvement.

However, the use of corticosteroids is not easy. Prescriptions for a limited time are not appropriate. A dose must be used until the acute cases start to improve, and only after that the drug dosage should be progressively reduced. Many times a maintenance dose is needed. It is accepted that a dose of 40 to 60 mg is sufficient to control type 1 or 2 reactions. This margin of 40 to 60 mg implies that there are cases that will respond well to 40 mg, 50 mg or 60 mg, and being so, with which dose should the treatment be started ? One answer would be to initiate with

a 40 mg dosage, and if the patient, does not improve, increase to 60 mg. How can it be done if the recommendations of the manuals are that a dose needs to be reduced after a few days it has been administered?

The answer would be that this a question of good sense and the doctor has known what to do in such circumstances. And the paramedical worker, that are the who treat the patients in many places, do they have enough medication? And are they able do act in such way?

It does not matter if it is a doctor or a paramedical worker who is treating this individual with a reaction, the case is that many times there is no therapeutic response and complications due to corticotherapy may also happen.

What is happening with those patients that were released from treatment and keep having reactions in all the endemic countries? The paramedical workers are no longer obligated to treat them because they are cured and also the records of these cases are not maintained.

In Brazil, what is being seen in some regions where the doctor is the one who does the treatment of these patients is that corticosteroids are frequently utilized, inclusive in cases in which they were not necessary and contrary to what was said before; high doses of the medication are maintained for a long time. There are a lot of patients with edema resulting from therapy wondering for hospitals to control their reactions and trying to withdraw the steroids. On the other side, there is the patient who knowing the drug action takes it by its own means trying to get rid of his symptoms, creating more problems.

To complicate even more the situation, there are those cases with uncontrolled neuritis. It is interesting to read in text books about the treatment of neuritis. In those, the problem seems to be much simpler. The truth however is that many cases cannot be resolved satisfactorily. It is not known for sure when a surgical procedure in

the nerve has to be done or if it is needed at all. The worst of all is that many things about neural involvement in Hansen's disease are still unknown. Thus, the nervous lesions that are responsible for most of the disabilities occurring in patients, and for the deformities that maintain the "tabus" and prejudices related to a disease that is "contagious and deforming". do not have a satisfactory treatment yet.

Today over 600.000 new Hansen's disease cases are diagnosed every year, only in Brazil 45.000, and almost all of them present already a defined clinical form at beginning of the treatment, they are tuberculoid, borderline or lepromatous. Therefore, they are susceptible to reactions during or after released from treatment, with all its consequences, without mentioning those multibacillary patients that when diagnoses had already contaminated a certain number of individuals.

The only way to solve all these problems would be to diagnose the new cases in the beginning and treat them with the MDT. However, it is necessary to remember in the 50's it was already known that sulphone could prevent that indeterminate Mitsuda negative cases were developed into a future contagious resource and that the discovery of these patients in this phase would extinguish the disease, but not much was accomplished in this respect.

That is why the coming year of "Elimination" is being seen with great apprehension, in which Hansen's disease will no longer be considered a public health problem, it would no longer be a priority infectious disease for the WHO, there will be, of course, a reduction of financial support invested by Health Ministers in endemic countries for the control of the disease and worst of all, we will continue with a massive number of diseased people that won't be considered patients with Hansen's disease.

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