

Assessing the Reality of Leprosy in a Tertiary Care Hospital in South Gujarat: Insights from an Endemic Region of Western India Two Decades Post-elimination

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India contributed 57% of the total new cases detected worldwide in the year 2019-20. Though Gujarat achieved the elimination target in October 2004, the annual new case detection rate (ANCDR) remained quite high for several years, it came down during the period. The study assessed the profile of leprosy at GMC, Surat - a tertiary care hospital of Gujarat, western India. A total of 202 participants with cardinal signs of leprosy new cases, excluding completed or on-treatment during April 2020 to March 2021 were enrolled in the study. A detailed clinical evaluation was done included evaluation of presence of reactions, deformities, and disabilities. Relevant investigations, slit skin smears, and a biopsy were performed. The mean age of participants was 36.6 ± 14.6 years, with a M:F ratio of 2.1:1. Cutaneous manifestations were observed in 84.2% of participants, while 15.8% had only pure neuritic leprosy. 51% of cases belonged to borderline spectrum of leprosy. Disability and deformity were present in 47.0% and 36.6%, respectively. Smears were positive in 42.6% of patients. 77.2% of cases studied belonged to multibacillary types as per NLEP criteria. Clinico-histopathological concordance in 123 cases, who consented for biopsy, was found in 87.8% of cases. The clinic-histopathological correlation was more at the poles of leprosy. Positive family history was found in 24 (11.9%) participants showed presence of source cases in the community. Only 46/202 (22.8%) participants presented within 6 months indicating delayed diagnosis. The study indicates the need of intensification of leprosy control activities in catchment areas of this tertiary care centre with a special population on migrants from other parts of India. There is apparent need to focus on awareness campaigns and training of health professionals to suspect / diagnose leprosy timely especially pure neuritic leprosy.

Keywords : Leprosy, Epidemiology, Histopathology. Tertiary Care Hospital, India

Introduction

Globally, during the 2020 COVID-pandemic, the annual new case detection rate (ANCDR) was reduced to 36.6% (WHO 2023). The ANCDR at the national level was 4.6/100,000 in 2020-21 (NSP 2023-27). Gujarat achieved the elimination target in October 2004, however, new cases are

continuing to be detected in the state and ANCDR remained above 5/100,000 to March 2020 (NLEP Gujarat 2020), which decreased to 3.6 during the 1st year of the pandemic (2020-21). While ANCDR is a better indicator than the prevalence rate (PR) for leprosy control there will always be undetected or hidden cases, as well as chances

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of over-diagnosis (Rao & Lakshmi 2005). Earlier studies from Surat area showed that leprosy in migrants was an important issue (Chudasma et al 2007). Even though data from tertiary care centres will not be representative of situation in the community, it would flag important issues to be focused at community and institution level. The study explored the clinico-epidemiology profile of leprosy at this tertiary care hospital from Surat to identify/understand the current issues.

Methodology

The present cross-sectional study was conducted at Dermatology department of Govt Medical College Surat, a tertiary care centre, from April 2020 to March 2021 after approval from the institutional ethics committee (no. GMCS/STU/ETHICS/APPROVAL/6735/20).

Operational definitions used in the study include:

- 1) Participants up to the age of 14 as per WHO criteria for leprosy were considered children.
- 2) Cases were classified based on place of residence as a study area for those belonging to south Gujarat, comprising seven districts and the rest as migrants. Migrants were classified as distressed migrants (as per United Nations criteria), migrant workers, and family members of migrants based on purpose.
- 3) The clinical spectrum of the patients was decided as per the Indian Association of Leprologists, 1982 (IAL 1982), and used for all comparisons as a baseline.
- 4) Slit skin smears (SSS) were taken from the right earlobes, forehead, dorsa of hands, left buttock, and skin lesions.
- 5) Cases were also classified as per the Ridley-Jopling (RJ) scale based on clinical features, SSS, and histopathological findings (Ridley & Jopling 1966).
- 6) Disabilities and deformities were graded according to the WHO grading system (Brandsma & van Brakel 2003).
- 7) Classified into paucibacillary (PB) and multibacillary (MB) types as per WHO criteria (1988) followed by our national programme (NLEP 2013).

Using the non-probability purposive sampling technique, all consecutive cases with cardinal signs of leprosy were screened and evaluated independently by two dermatologists and confirmed by the first author. The inclusion criteria were new cases of all age groups with cardinal signs of leprosy attending dermatology OPD and willing to give informed written consent (ascent for <18 years). Participants who were on treatment or had completed multi-drug therapy were excluded from the study. At the end of the study period, we were able to recruit 202 participants from April 2020 to March 2021.

All the participants were subjected to a thorough clinical history and local examination, including a neural, sensory, and motor examination. Physician opinion was taken in all cases of peripheral neuropathy. A punch biopsy was taken from the skin lesion after obtaining consent. We have not performed a nerve biopsy on any participants because of their denial of consent. 72.4% (123) participants gave consent to a punch biopsy, while none agreed to nerve biopsy. Other relevant investigations as per the case, including nerve function studies, were done.

Analysis: The data were collected in Microsoft Excel 21 and the mean and proportions were analysed. Evaluation was done according to NLEP indicators for the cases belonging to South Gujarat.

Results

The mean age of participants was 36.5 ± 14.6 years. Of the total 202 participants, 98.5% were adults, and only 1.5% were children. The

Table 1 : Baseline data of leprosy cases (n=202).

Spectrum of leprosy as per IAL		TT	BT	BB	BL	LL	PNL	Total no. of cases
Gender	Male	19	33	4	34	23	25	138
	Female	7	19	0	20	11	7	64
South Gujarat	Urban	14	18	2	13	12	14	73
	Rural	1	8	1	17	8	3	38
Migrants	Distress migrants	2	7	1	14	5	7	36
	Workers	5	12	0	7	6	6	36
	Family members	4	7	0	3	3	2	19
Bacteriological index as per Ridley	Zero	26	52	0	5	1	32	116
	1+	0	0	0	0	0	0	0
	2+	0	0	3	11	0	0	14
	3+	0	0	1	20	2	0	23
	4+	0	0	0	15	14	0	29
	5+	0	0	0	3	13	0	16
	6+	0	0	0	0	4	0	4
Histopathological type as per Ridley Jopling classification (n =123)	TT	24	3	0	0	0	0	27
	BT	2	30	0	1	0	0	33
	BB	0	3	3	0	0	0	6
	BL	0	1	1	34	1	0	37
	LL	0	0	0	3	17	0	20
*NLEP classification	PB	22	15	0	0	0	9	46
	MB	4	37	4	54	34	23	156
*WHO classification	PB	16	3	0	0	0	0	19
	MB	10	49	4	54	34	32	183
GRADE I disability	EYES	0	3	0	7	9	0	19
	HANDS	0	1	0	9	3	1	14
	FEET	0	0	0	10	13	7	30
GRADE II disability	EYES	0	0	0	0	2	0	2
	HANDS	1	2	0	10	18	19	50
	FEET	0	0	0	3	7	9	19

*As per WHO classification (1988) smear examination was required, which was removed by WHO in 2002. Subsequently as per NLEP, smear examination was not required leading to differences in numbers classified as PB/MB.

Table 2 : Comparison of national leprosy control program indicators.

Indicators of NLEP (2020-21)	National level	State level
New Case Detection	65147	2580
PR	0.40	0.24
Female case	26059	1054
Child case	3753	141
Grade-II disability cases	1572	2
Grade- II deformity in child cases	35	0
No. of MB case	37848	1413
Percentage of MB cases	58.1%	54.8%

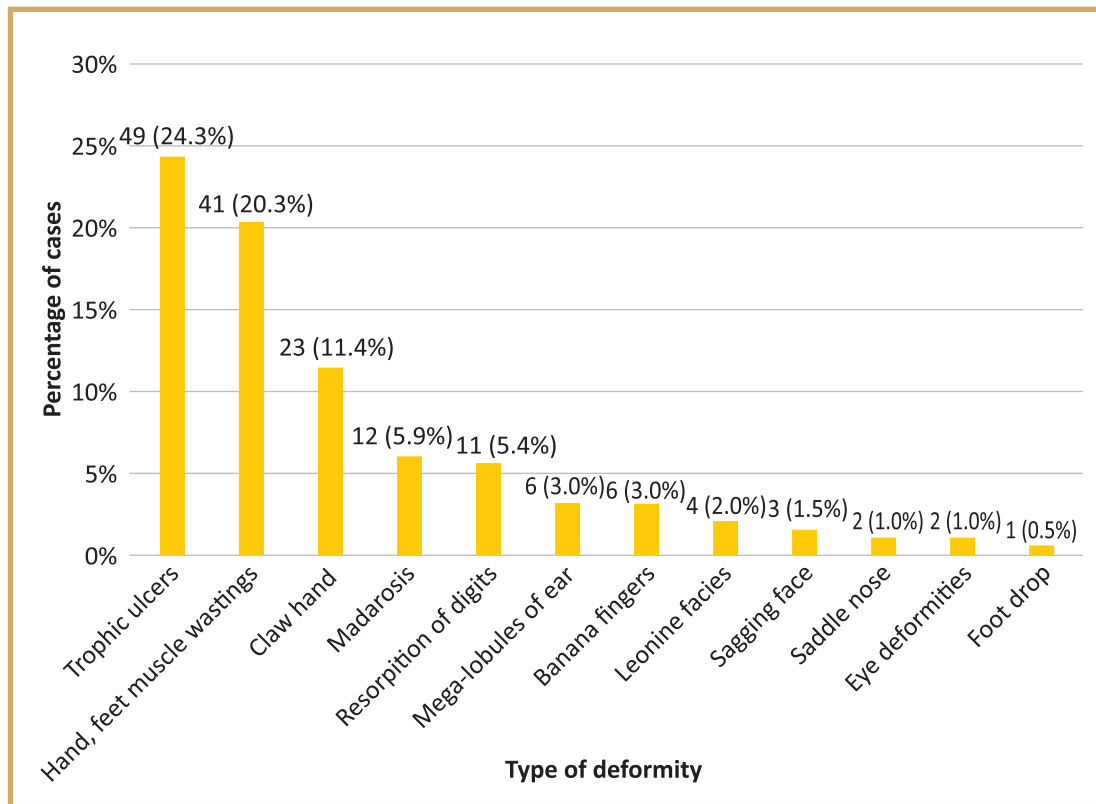


Fig. 1 : Distribution of cases according to type of deformity (n = 76).

youngest patient was 5 years old, and the eldest was 86 years old, with a male-female ratio of

2.1:1 (Table 1). As per the modified BG Prasad scale (2021), 45.0% (91) participants belonged

to the lower class, followed by 27.7% (56) of the lower middle class, 12.9% (26) of the middle class, 9.5% (19) of the upper middle, and 4.9% (10) of the upper class. Positive family history was found in 24 (11.9%) participants, with parents 7 (3.5%), spouses 6 (3.0%), children 6 (3.0%), and siblings 5 (2.5%). Two participants had two family members affected. None of the participants gave a positive history of neighbourhood.

According to the duration of the onset of symptoms, 46 (22.8%) participants presented within 6 months, 83 (41.0%) between 7 and 12 months, 33 (16.3%) between 13 and 18 months, 29 (14.4%) between 19 and 24 months, and 11 (5.4%) participants presented after 24 months of symptoms. Participants presented with one or more complaints. 19 (9.4%) participants had only cutaneous involvement and 74.8% had both cutaneous and peripheral nerve involvement. 28 (16.5%) participants had a single cutaneous lesion. Pure neural type of leprosy (PNL) was present in 15.8% of participants, in form of mono-neuritic (9 cases) and poly-neuritic leprosy (23 cases). None of the participants was found positive for the rapid antigen test nor gave a history of COVID-19 infection.

SSS was positive in 86 (42.6%) participants. Correlation between clinical diagnosis and histopathological diagnosis were found in 87.8% of 123 cases studied. Histopathology confirmed histoid type among 3 cases of lepromatous leprosy (LL).

Multiple deformities (37.6%) in one or more forms at the time of presentation were found in more than one third of the cases (Fig. 1). Multiple disabilities (total 134) in one or more forms were present in 95 (47.0%) participants. Lepra reactions were present in 23 (11.4%) cases, of which type 1 reactions were seen in 3.5% and type 2 reactions were seen in 7.9% of patients.

A total of 65 other dermatological conditions were observed along with leprosy: Pityriasis versicolor (15.3%), Dermatophytosis (8.9%), Verruca vulgaris (3.0%), Molluscum contagiosum (2.0%), Vitiligo (2.0%), and Secondary Syphilis (1%). Vitiligo coexisted as an acro-facial type in two BT cases, a mucosal type in one TT case, and a focal type in one LL case. Cases of secondary syphilis were confirmed by serological testing. Systemic conditions were diabetes mellitus (11.9%), hypertension (8.4%), anemia (4%), thyroid disorders (1.5%), tuberculosis (1.0%), and PLHIV (0.5%).

Discussion

The study period matches the reporting format for leprosy in India from April to March. Leprosy can occur at any age, but it is most commonly detected in the age group between 20 and 30 years (Joshi 2017, Yawalkar 2009). Our study also had nearly 1/3 of cases in this age group. The proportion of child cases at the national and state levels (National Strategic Plan 2023-27) was 5.8% and 5.5%, respectively, during 2020-21 (Table 2). Though child cases comprised of only 1.5% in our study group as seen earlier (Chudasma et al 2007), it will be important to study this aspect in the studies at community level. Though leprosy is less common in children, the proportion of paediatric cases in the population has epidemiological significance as it indicates active disease and recent transmission in the community. According to literature reports, males are affected more than females, in the proportion of 2:1, as also reported in the present study. A higher number of male cases could be attributed to their greater mobility and increased opportunity for contact (Joshi 2017). As per the NLEP data for Gujarat state, the percentage of female cases registered in the year 2020-21 was 40.9%, which is higher than the current study. This might be because to the industrial districts and the difficulty that

women had in accessing healthcare during the pandemic. The urban-rural case ratio for Surat district was nearly 2:1. Migration from rural to urban resulting in carriage from rural to slum, slum to urban middle class and villages. Due to the migration of the population from rural to urban areas, leprosy cases have increased in urban areas in recent years. As per the UNESCO report (Social Inclusion of Internal Migrants in India 2013), migrants comprise almost 58% of the population in Surat city, as also in the study (45% of migrants). Chudasma et al (2007) also reported an increase in leprosy cases in Surat district because of migration. Intensive efforts to enhance the access of leprosy programme to migratory population groups thus deserve high priority.

Our city is highly industrialized; 43% of cases were workers, while 14.3% were unemployed, which may be due to the loss of employment during the pandemic. The maximum number of cases reported in the study by Giridhar et al (2012) were labourers (34.6%), while another study reported 17.7% (Gupta et al 2019).

We found the majority (45.0%) of the patients belonging to lower socioeconomic classes. Leprosy is a social disease associated with overcrowding, a lack of education, a lack of personal hygiene, and a lack of ventilation, which favours transmission of the disease (Joshi 2017).

Positive contact history (family or neighbourhood) of 8.3% (Thakkar & Patel 2014) and 9.5% (Salodkar & Kalla 1995), were comparable to our study. The occurrence of leprosy in families may be due to similar environmental conditions, close contact, or genetic similarity, with higher probabilities in lepromatous cases. The lack of knowledge about leprosy and, at times, associated stigma may prevent patients from disclosing the details of their disease to even close contacts, as none of the participants gave a

history of the neighbourhood. Low percentage of family/ close contact source cases indicates the need to strengthen community -based screening efforts to identify other sources of continued transmission.

Initial symptoms and fewer lesions were ignored by the patients (62.1%) not having knowledge about the severity of the disease, resulting in late reporting (> 1 year) to a health care facility, which led to the advancement of the disease with higher chances of deformity (45.6% of cases with >2 years) and disability (81.9% of cases with >2 years). Comprehensive research cum intervention studies are required to change this situation so that cases are diagnosed in time and treated appropriately. Health care workers including treating doctors need to be up-to -date about clinical aspects, differential diagnosis and classification issues adequately (Ridley & Jopling 1966, IAL 1982, NLEP 2013, Rao & Suneetha 2016, Kumar & Dogra 2017, Kaviasaran & Prasad 2022, Suneetha 2022).

Clinical features are the result of the host response to the bacilli rather than of direct damage due to bacillary invasion (Kumar & Dogra 2017). The protective immunity against leprosy is inversely related to the number of lesions or body areas affected, as nearly 75% of participants (borderline spectrum and LL) had multiple lesions or sites involved (Rao et al 2005). Peripheral nerve involvement in one or another form (90.6% in the present study) among newly diagnosed MB and PB cases was reported at 91% to 96% and 76% to 86%, respectively, in other studies (Kumar & Dogra 2017). PNL type is reported more frequently in India than in other countries, with a frequency of 4% to 18% (15.8% of the study) with more than one nerve involvement in over 60% of cases and male predominance (78.1% of the study), in different studies (Rao & Suneetha 2016). The percentage of mononeuritic

leprosy (28.1%) and polyneuritic leprosy (71.9%) was comparable with another study done in a nearby district of the state (Thakkar & Patel 2014). A nerve biopsy is required to establish the diagnosis according to the spectrum. It presents as peripheral neuropathy in the form of nerve enlargement with nerve function impairment without a skin lesion, suggesting leprosy, and may lead to delayed diagnosis and disability. The ulnar and common peroneal are the most commonly infiltrated nerves in leprosy (Kumar & Dogra 2017).

As per the literature, the sensitivity of the SSS report is low, as also reflected in our study's positivity of 42.6%. The smear positivity was reported in 10–50% of all cases in various studies. Skin smears have traditionally represented one of the cardinal signs of leprosy, with a specificity of 100% (Kumar & Dogra 2017). According to the literature, pure neuritic leprosy -PNL is a type presenting as peripheral neuropathy without visible skin lesions or bacilli in SSS, as in our study (Rao & Suneetha 2016). Smears for acid-fast bacilli are usually reported as negative in the TT and BT spectrums, usually positive in the BL type, and consistently positive in the LL spectrum, which is also reported in the current study (Suneetha 2022).

Clinicopathological concordance was reported in a range for each type of leprosy from different studies (Kakkad et al 2016) for the TT spectrum (46 to 100%), BT (53 to 82%), BB (37 to 65%), BL (36 to 95%), and LL (8 to 93%). In the present study, 90% correlation was observed in the TT, BL, and LL poles, with an overall concordance of 87.8%, comparable to other studies (Kakkad et al 2016). Clinical diagnostic accuracy, when compared to histopathology, was found to be higher (>90%) in polar forms (TT and LL spectrum) than in the borderline spectrum. The clinical classification gives recognition only

to the gross appearances of the lesions, while histopathological examination depends on the site as well as type of skin lesions. The disparity could be due to different stage of presentation, type and site of lesion from where the biopsy was taken. It helps in predicting the course, reactions, and complications depending on the spectrum (Kumar & Dogra 2017).

More than fifty percent of the cases belonging to the borderline spectrum, were comparable with Gupta et al (2019) and Jindal et al (2009). Early evolution of lesions can be easily missed as it is of least concern to the patient and may degrade, which could be a cause for the detection of a large proportion of patients on the borderline spectrum. More than one-fourth of the cases were from the BL spectrum, which was comparable to the 31.2% reported by Thakkar & Patel (2014).

The patients are categorized into PB or MB leprosy (ratio of 1:9 in the present study) depending upon whether the SSS demonstrate any bacilli or not as per WHO criteria (1988). SSS remains the gold standard for the classification (Kumar & Dogra 2017). According to the NLEP criteria, the percentage of MB cases in the study populations (73.7%) was higher than reported at state (54.8%) and national levels (58.1%) for 2020-21. The higher proportion of MB cases is an indicator of delayed diagnosis and could be a sign of the existence of inaccessible pockets of the population harbouring undiagnosed leprosy cases for a long time or a lack of awareness or access to services in the population. MB cases have epidemiological importance, as they are a major reservoir of infection and also vulnerable to reactions and subsequent deformities. The ratio of type 2 reactions was twice that of type 1 in the study. It is very essential to recognize reactional leprosy irrespective of the type of reaction, as cases of type I reactions are more

prone to deformities and type II reactions are more prone to systemic complications (Gupta et al 2019).

In our study, disability (both grades) was present in 47.0% of cases, which is comparable to 48.7% of the study by Reyila et al (2019). The Grade 2 disability (G₂D) rate of our study (1.01% considering the seven million city populations) was higher than the state level (0.03%), but lower than the national level (2.4%) of the same period. The G₂D rate was comparable to the study of Reyila et al (2019). (31.6%). G₂D indicates a delay between the patients getting infected and seeking treatment for it. A high bacillary load had contributed to an increased G₂D rate. Patients with borderline disease suffer most of the disabilities and deformities seen in leprosy (Kumar & Dogra 2017). Deformities might be due to ignorance, late diagnosis, higher bacillary load, inadequate treatment of reactions, or neuritis. Besides these aspects, public health action for their correction and rehabilitation also needs to be given proper attention.

A total of twelve types of deformities with the most common being trophic ulcers (nearly one-fourth of cases), were observed in the present study. Rathod & Mistry (2017) also reported trophic ulcer as the most common deformity (24.3%), along with claw hand (11.4%), madarosis (3.2%), and resorption of digits (3.2%).

Though the leprosy control program was also significantly affected by the COVID-19 pandemic, it will be difficult to comment on its effect on clinical profile, delays and adverse outcomes without detailed comparisons with disease parameters over the last several years.

Conclusion

A higher proportion of multibacillary cases with high percentage presenting with deformities at presentation in the post-elimination era requires

an intensification of leprosy control activities in this area which should be led by evidence generated by appropriately designed research cum intervention studies in this area.

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