

We Need to Know Reasons for Delay in Diagnosis

Access to services is key to success of any programme. This is especially important in leprosy so that disabilities due to disease are made zero and transmission is also totally interrupted. Ensuring early diagnosis by strategy of repeated surveys, education and empowerment of health workers and the general population, and prompt treatment has been the important approach of National Eradication Programme (NLEP) to achieve this goal of early diagnosis. With widespread use of multi-drug therapy through a vertical national programme supported by several non-governmental organizations (NGOs), India achieved the goal of elimination of leprosy as public health problem (prevalence less than 1/10,000) in 2005. This meant reduction of more than 96% from the pre-MDT time and will always be remembered as an important success story of public health.

It is also a well-known fact that the progress of next 20 years of NLEP as a part of horizontal integrated programme has not been that spectacular. It has been nearly stagnating and there is a very slow decline in the number of new cases detected. National sample survey which covered all the states and union territories showed that leprosy affected persons ignore the initial symptoms and actual prevalence could be 2.5 to 3 fold than those reporting to health care facilities. This means continued transmission for a much longer duration and disabilities caused by nerve damage are already set in before the affected individuals report to treatment facilities. NLEP has tried to bridge the gap by

awareness campaigns and also periodic active case detection and active contact tracing and examination. However, these are not exactly targeted campaigns based on understanding of local factors responsible for such delays especially in communities disadvantaged possibly due to social, geographic and behavioural reasons.

Recent NLEP data shows that we are progressing well as is inferred from prevalence, annual new case detection rates, child rates, MB/PB ratio etc. Public health response is focused on areas with higher numbers. We are likely to have better data with the disease being made notifiable and data becoming available on Nikusth 2 to analyse and re-model our approaches. However, we should accept that figures do not tell the reasons unless that information is specifically elicited.

Recent publications and many over the last 10-15 years from tertiary care centres show very high proportion of lepromatous leprosy, and some cases with very high bacillary index (BI). Availability of histopathology examination and slit skin smears have contributed to this information. However, in the recent years availability of molecular based methods including on TruNat platform from India have changed the scenario. These technologies have become point of care and practicable in peripheral centres as well. These would help in definitive early diagnosis of leprosy at primary care centres also.

Many of such cases might have been missed due to lack of compelling symptoms. It is also possible that many would have been missed by health professionals due to diffuse infiltrative nature

of involvement and lack of proper examination of peripheral nerves which is not part of usual teaching or training. Further, the proportion of cases with disabilities reporting to specialized institutions/ tertiary care centres is also quite high. Though these figures do not reflect the actual quantitative assessment of situation at community/ population level these do show that access to services is still a problem leading to continued transmission and disabilities, both of which were preventable. It is unfortunate that profiles of leprosy cases reporting to tertiary care or similar other institutions are presented as such with little data on the aspects throwing light on possible reasons. These figures do not provide any guidance about the way forward to prevent late reporting. As a result, our campaigns are stereotyped efforts and we are not making any focused effort based on actual data for reasons

for delay in diagnosis for LL and also other types of disease.

Considering these issues, we need to focus on strengthening academics and research environment at medical college / any tertiary care institution level. Professional bodies like IAL/IADVL/ others have immense role to play in this regard. Questions should be how and why, not merely numbers detected which are being reported. Leads from these studies with minimum or no additional financial burden can change the entire scenario. Such information will enable our national programme as well as agencies to come out with meaningful research cum intervention studies/ efforts to achieving lasting success. It is time to ponder and change our mind-set and approach.

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