

Community Eye Health Care for Leprosy Patients in West Bengal, India

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Leprosy and Eye Disease in West Bengal

Leprosy is endemic in West Bengal, particularly in the five districts of Burdwan division in the southern part of the State. The endemicity rate of the disease in the districts of Bankura, Midnapore, Purulia, Birbhum and Burdwan under this division varies from 10 to 12 per thousand of the population (the total population of this division is around 30 million). Here most of the patients have paucibacillary (PB) leprosy (75%) and the rest have multibacillary (MB), like other parts of India. Of these patients, 15% had ocular lesions and 1.5% were blind due to the complications of leprosy whether from complicated cataract or uveal affection.¹ Recently, under the National Leprosy Eradication Programme, the successful implementation of Multi-Drug Therapy according to WHO recommendations

declared most of the patients as 'RFT' (Released From Treatment). A study on 'RFT' patients (with an equal number of PB and MB cases) showed that 52% had eye disease, 70% of which developed as a result of leprosy.² Of this group, 28% of after care leprosy sufferers have 'high risk eyes', i.e., the aftermath of leprosy, although they are discharged from active systemic anti-leprosy treatment.³ Lagophthalmos with hypoesthetic corneas (with or without exposure), chronic dacryocystitis, recurrent attacks of uveitis, one-eyed individuals, mutilated as well as ulcerated extremities, with maintenance of poor personal ocular hygiene, make those 'after care leprosy sufferers' always at risk. They may develop severe ocular inflammation leading to irreversible blindness consequent to the lack of proper supervision and early intervention.

Eye Care for Leprosy Patients

Most of these after care leprosy sufferers live in colonies with their families. Being outcast from healthy society due to the stigma of the disease they have 'accepted' this isolated life with an idea of living in a world out of the world. They mainly thrive on cultivating vegetables and fruits, goat keeping, daily labour on farms, rickshaw-pulling and as cleaning staff of the municipal towns. Until 1990 it was very difficult to perform cataract surgery or other operations on these poor patients in general hospitals, again due to the stigma. So an 'eye camp approach' in the leprosy hospital had been adopted to tackle the huge burden of cataract blindness in leprosy. In the 1980s under the National Programme for Control of Blindness the 'after care leprosy sufferers' organisation, (namely Pashim Banga Kustha Kalyan Parishad and Mahakuma Kustha Nibarani Samity) used to organise and volunteer their service towards the nursing as well as the paramedical tasks required to conduct these eye camps solely for leprosy sufferers.⁴ The authors, with the help of their mobile eye unit, used to perform intracapsular cataract operations, pterygium surgery, dacryocystectomy, and other



Leprosy in West Bengal, India

Photo: S K Samanta & I S Roy

operations with a 90–95% successful operative outcome.

Leprosy Patients in the Community

But the concept as well as the certification of these 'RFT' patients have revolutionised the total picture of the current day community eye health care programme amongst leprosy sufferers. Today there is no bar to former leprosy patients with the 'RFT' certificate being admitted into a general hospital as the doctors, nurses and paramedics are free from fear of the disease. On the other hand, eye camps are still going on in community halls or primary school buildings in the leprosy colonies or in the temporary eye wards of the leprosaria (government leprosy hospitals or the hospitals run by The Leprosy Mission). Amongst these patients attending the camp there are both after care leprosy sufferers of the colonies and healthy individuals from the surrounding villages. These eye camps are being organised jointly by the after care leprosy sufferers organisation, local panchayet (the lowest democratic administrative level of a cluster of villages) and an NGO, like Lions and St John Ambulance Association. It is really community participation beyond all fear, anxiety and stigma when leprosy sufferers and healthy individuals are found side by side on the same floor of the eye camp receiving nursing care as well as the food served and prepared by the after care leprosy sufferers. In 1996, two such eye camps were organised in the district of Bankura – one at The Leprosy Mission Home and Hospital, Bankura with the help of the Lions Club of Bankura and the other at the Peardoba Leprosy Colony, Peardoba, Bankura with the help of the Bankura district centre of St John Ambulance Association. In the first camp 18 mature cataracts and one pterygium, and in the latter 15 cataract and 6 pterygium were operated on, with 97.5% success. (Only one female patient, one-eyed, developed endophthalmitis six months after surgery).

Lastly, another notable feature in the



After eye camp cataract surgery

Photo: S K Samanta & I S Roy

community ophthalmic picture is the easy acceptance of the after care leprosy sufferers (each with an RFT certificate) in the mass eye camps organised outside the arena of the leprosarium. The leprosy sufferers are not kept in a separate room but receive all the care given to any other healthy individual, staying side by side in the same temporary wards.

In the context of the Indian scene of

leprosy care, and after care, this unique change of attitude is a positive outcome in our day to day community ophthalmic practice.

References

- 1 Samanta SK, Roy IS. The current status of ocular leprosy – a cross sectional survey. Proceedings of the All India Ophthalmological Society Golden Jubilee Conference, New Delhi. 1992: 685–7.

- 2 Samanta SK, Roy IS. Ocular problems in cases released from treatment. *Int J Lepr* 1993; **61**: 117–8.
- 3 Samanta SK, Roy IS, Marandi A. High risk eyes in leprosy. *Indian Ophthalmology Today*. 1993: 574–6.
- 4 Samanta SK, Dey B, Adhikary S, Roy IS. Participation of after care leprosy sufferers in comprehensive eye health care service for fellow patients. Health Co-operation Papers – O.C.S.I. Abstracts of the 13th International Leprosy Congress. The Hague. 1988: 471. □

Abstract

Risk Factors for Noncompliance with Glaucoma Follow-up Visits in a Residents' Eye Clinic

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Objective: This study aimed to identify factors associated with compliance with glaucoma follow-up visits.

Design: Computer records of a university residents' eye clinic were reviewed to identify a random sample of all persons who had an examination with International Classification of Disease (ICD) 9 coding (ICD9) for glaucoma suspect or glaucoma

during a 2-year period (1991–1993) to undergo telephone interview.

Participants: Those who were seen at least every 6 months regardless of earlier return instructions were defined as compliant with follow-up (controls n = 362). Those who had any lapse between visits of longer than 6 months were defined as noncompliant (cases, n = 362).

Results: Interviews were completed for 196 cases and 242 controls. Noncompliant persons were significantly more likely to be suspects for glaucoma rather than have definite glaucoma and to be dissatisfied with waiting time in the clinic (29.1% vs. 17.8%, $P < 0.005$) and to state that they did

not take their glaucoma medications as prescribed (25.4% vs. 13.4%, $P < 0.004$). They also were less likely to have been prescribed eyedrop medication. A high percentage of both patients and controls knew that glaucoma can lead to blindness (85.2% and 88.4%, respectively). The most common reasons patients gave for not keeping follow-up visits were the perception that their eye problem was 'not serious enough', the cost of examinations, and that the doctor did not tell them to come back.

Conclusion: Compliance with follow-up visits for glaucoma is associated with markers for early disease. Attempts to improve compliance might focus on improved communication of the seriousness of the disease and improvements in clinic waiting time.

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