Memorandum on leprosy / Department of Health and Social Security and the Welsh Office.

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
AND THE WELSH OFFICE

Memorandum on Leprosy

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FOREWORD

This memorandum, which describes the clinical and epidemiological features of leprosy and gives the names and addresses of the members of the Panel of Leprosy Opinion who are available to give expert advice, has been prepared by Dr. S. G. Browne, CMG, Consultant Adviser in Leprosy to DHSS, in consultation with expert leprosy opinion throughout the country. It replaces the previous edition issued in 1966.

Leprosy was made notifiable in 1951. Since then 1,024 cases in all have been reported to the Chief Medical Officer of DHSS up to November 1976. Only 20 cases were reported in 1975, the smallest number in any year since 1951, and no indigenous case has been reported during the whole of the 25 year period. The importance of leprosy to doctors in this country, however, lies not in the numerical size of the problem but in the special considerations affecting the need for early diagnosis and expert treatment.

We should like to express our indebtedness to Dr. Browne for revising the memorandum and to all those who were consulted and made contributions during its preparation.

SIR HENRY YELLOWLEES
Chief Medical Officer
Department of Health and Social Security

R. T. BEVAN
Chief Medical Officer
Welsh Office

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MEMORANDUM ON LEPROSY

Notes on leprosy in England and Wales

Revised by Dr. S. G. Browne, CMG, OBE, Consultant Adviser in leprosy to the Department of Health and Social Security

1. This Memorandum on leprosy replaces that issued by the Ministry of Health under cover of CMO 1/66.

2. Leprosy is an uncommon disease in England and Wales. The table (Appendix II) shows the number of notifications received each year by the Chief Medical Officer to the Department since the disease first became notifiable in 1951. In the 25 years since then, a total of 1,024 cases has been notified of whom only 370 remain on the Central Register of Leprosy, under treatment or surveillance.

3. Notwithstanding the entry into Britain of persons who have lived in countries where leprosy is endemic, the actual number of leprosy notifications is not as high as might be expected and generally the proportion of leprosy sufferers among immigrants is probably lower than among their fellow-countrymen in their homelands. Furthermore, despite the presence in Britain of patients known to have active leprosy, and probably of others with unrecognised and hence untreated leprosy, no case of indigenously contracted leprosy has been reported to the Department since the disease became notifiable.

4. The importance of leprosy in this country lies not in the actual size of the problem, but in the need for early diagnosis and expert treatment of those with active disease, and for assistance from the National Health Service and from Social Services Departments for those who are physically, psychologically or socially handicapped.

Epidemiological considerations

5. The distribution of leprosy cases in England and Wales is, as would be expected, roughly in proportion to the concentration of the immigrant population. The four Thames Regions account for just over one-half of the total, with the North Western, Yorkshire, Trent, Mersey and the West Midlands Regions together accounting for another one-third.

6. Fortunately, the great majority of leprosy patients who have been notified are not suffering from leprosy of a contagious variety or at a contagious stage. Most of these will have had treatment for the disease before coming to Britain.

7. Although leprosy is frequently contracted in childhood or adolescence, it may not reveal itself in symptoms or signs for several years—the silent or incubation period is commonly from two to five years, possibly longer.

8. The infectivity of leprosy is a function of the concentration of leprosy bacilli in the body of the patient and the chances of viable bacilli emerging and remaining viable and pathogenic to susceptible contacts. The first component reflects the degree of cell-mediated immunity that the host is able to mount. If this is considerable, then the patient (if he has indeed succumbed to leprosy infection) will be suffering from a tuberculoid or near-tuberculoid leprosy, and will rarely if ever be contagious. Leprosy bacilli in his tissues will be extremely scanty, the majority will be degenerate and non-viable, and the chances of living bacilli leaving the body are remote.

9. In lepromatous and near-lepromatous leprosy, however, bacilli are extremely numerous in many superficial tissues; in the lepromatous form, the nasal mucosa is heavily bacillated, and many millions of viable bacilli are discharged daily, many of which may remain viable for hours or days after leaving the body. Droplet infection would thus be the likeliest means of spread of bacilli.

10. Standard treatment rapidly reduces the numbers of viable bacilli in the nasal discharge, so that after six months' treatment with dapsone, or three weeks' treatment with rifampicin, all such patients may be regarded as virtually no longer contagious.

11. The other aspect of transmission concerns the susceptibility of close contacts exposed to massive and repeated infection. Although subclinical infections may be more frequent than is generally realised, yet only about 1% of any population would be completely unable to mount any degree of cell-mediated immunity and would thus succumb to lepromatous leprosy if adequately exposed. The rest would either not contract the disease at all, or have a sub-clinical infection, or a transient and self-healing form, or develop a slowly progressive paucibacillary form of leprosy.

12. With these considerations in mind, it is possible to assess the importance of advice on nasal and general hygiene, the clinical examination of contacts (especially contacts of patients with lepromatous leprosy), and the measures of notification and surveillance advocated.

Diagnosis

13. The possibility of leprosy should always be borne in mind when someone who has spent some time in a country in which leprosy is endemic, or comes from the tropics or sub-tropics, complains of a chronic non-itching patch in the skin that does not resemble a better-known condition and that does not respond to treatment. If there is some diminution in cutaneous sensitivity within an area of hypopigmentation, the diagnosis of leprosy becomes more likely. Similarly, if the patient presents with an ulcer on the sole of the foot or complains either of neurological symptoms that do not fit into a well-recognised pattern, or of signs of damage to a peripheral nerve trunk (particularly the ulnar or the posterior tibial), accompanied by a skin rash, then leprosy must be considered as a real possibility. (The lepromin test is of practically no value for purposes of diagnosis but is useful for confirming

classification on the immunological scale. Requests for the supply of Mitsuda type lepromin should be made to the Head, Laboratory for Leprosy and Mycobacterial Research, National Institute for Medical Research, The Ridgeway, Mill Hill, London NW7 1AA, Tel. No. 01-959 3666.)

Less common presentations of leprosy include any or a combination of the following:—

> acute uveitis, erythema nodosum, epistaxis, crusting of the nose, hoarseness, loosening of the upper centre incisors, paranoid symptoms, depression, and anxiety.

Most cases, however, are usually referred initially for a skin complaint to a consultant dermatologist.

Panel of Leprosy Opinion

14. In case of unresolved suspicion, or if desired on other grounds, advice may be sought from a member of a selected group of practitioners with experience of leprosy (Panel of Leprosy Opinion) who will, on request, assist Medical Officers for Environmental Health* and doctors in clinical charge of patients in their problems of diagnosis, potential infectivity, and management of the cases and their close contacts. A list of current members of the panel is given in Appendix I. Amendments to the list are issued from time to time by the Department.

Consultant Adviser in Leprosy

15. The Department's Consultant Adviser in Leprosy, Dr. S. G. Browne, CMG, OBE, (The Leprosy Study Centre, 57a Wimpole Street, London W1M 7DF, Tel. No. 01-935 5848) is available on request to visit and advise clinicians having leprosy patients in their care. He is also the Director of the Leprosy Study Centre which has links with leprosy institutes and field workers in many countries. On behalf of the Chief Medical Officer, the Consultant Adviser maintains a record of all cases notified which in many cases is correlated with histo-pathological data.

Laboratory investigations

16. Even though the diagnosis may be established on clinical grounds it is always essential to undertake microscopic examination of the nasal discharge and of smears from the active edge of a skin lesion or of material obtained by skin biopsy. The presence of acid-alcohol-fast bacilli in such material will not only confirm the diagnosis in clinically doubtful cases, but will also indicate that the patient is in a potentially infective state. The

*Medical Officer for Environmental Health (MOEH) is the short title of the "Proper Officer" appointed by a Local Authority for functions relating to notifiable disease and food poisoning, and as their medical adviser on environmental health. Where appropriate he also has responsibilities to a Sea Port Health Authority or to the local authority with responsibility for port health control at an airport.

histo-pathological picture may be characteristic and pathognomonic when bacilli cannot be demonstrated. A visit from a member of the Panel gives the best opportunity for smears and/or biopsies to be taken.

Microscopic examination of nasal smears and smear from skin ulcers

17. A drop of mucus from the nose (obtained with a throat swab after cleansing the nose with a pledgelet of cotton wool) is spread on a clean microscopic slide, allowed to dry, fixed and stained by Ziehl-Neelsen's method. Discharges from ulcers of the proximal skin (not from neuropathic ulcers of the extremities) may also contain viable leprosy bacilli.

Diagnostic skin biopsy

18. The recommended procedure for skin biopsy for leprosy diagnosis is as follows:—

(1) Select a representative lesion (or if necessary two lesions) and take the biopsy from the most active part; normal skin need not be included.

(2) The incision should be about 1·5 cm by 0·5 cm. Cut vertically down to the subcutaneous fat and include some fat. The scalpel is preferred to a punch biopsy.

(3) Excise the specimen with care and drop it into the fixative (Ridley's solution) which is obtainable from the addresses below. Record the biopsy site on the label of the bottle.

(4) After three hours pour off the fixative and replace it with 70% alcohol. Washing is not required.

Biopsy specimens may be despatched to one of the following addresses:—

(a) Dr. S. G. Browne, CMG, OBE, 57a Wimpole Street, London W1M 7DF, Tel. No. 01-935 5848.

(b) Dr. D. S. Ridley, Hospital for Tropical Diseases, 4 St. Pancras Way, London NW1 0PE, Tel. No. 01-387 4411.

Histopathological specimens from many patients now or formerly on the Central Register (see paragraph 40) are held at these centres for reference.

Notification

19. It is the responsibility of the doctor making the diagnosis to notify the case, under confidential cover, to the Medical Officer for Environmental Health of the Local Authority. The MOEH will in turn send a copy of this notification to the Chief Medical Officer of the Department of Health and Social Security* also under confidential cover.

*In Wales—The Welsh Office.

20. It is very helpful if the type of leprosy from which the patient is suffering is indicated when the case is first notified. If at this time a provisional classification only is possible, based generally on clinical considerations, a definite classification should subsequently be made and reported to the MOEH as soon as further information becomes available, usually from histopathological data. The classification most generally practicable and useful is one based on clinical, bacteriological and immunological considerations, and is represented thus:—

LL polar lepromatous;
BL borderline lepromatous;
BB borderline;
BT borderline tuberculoid;
TT polar tuberculoid.

Management of the patient

21. It is recommended that a member of the Panel should be invited to see and discuss the management of:—

(a) all new cases within a reasonable time of diagnosis;

(b) previously notified cases when decisions as to their infectivity, or change of treatment, have to be made;

(c) patients living at home who either fail to attend for treatment, fail to respond to it or present special problems.

The needs of the individual patient, from the clinical point of view, comprise specific treatment of his infection and the management of the various complications and sequelae which may result from it.

22. Most patients can be treated as out-patients, with no danger to themselves or to others. For the most part, patients remain in the care of general medical practitioners and consultant dermatologists with the advice and help, where necessary, of a member of the Panel of Leprosy Opinion. Treatment for leprosy may be prescribed with one or other of the standard drugs available on prescription, or perhaps a combined regimen of two or more drugs.

23. The patient who lives at home will need supervision and encouragement to ensure that he takes treatment as prescribed and reports regularly for follow-up examinations. He may need advice or help with general social problems, housing, and employment. In some cases action may be required to obviate the possible risk of spread of the disease to persons in close contact with the patient in the household (see paragraphs 36 and 37).

24. Patients who have suffered from lepromatous or borderline leprosy should continue taking treatment for life, even after clinical quiescence (non-activity of the lesions) has been attained. It is advisable for such patients to be reviewed clinically at least once a year by a doctor experienced in leprosy.

25. Patients who have had tuberculoid or near-tuberculoid leprosy may in most cases cease taking antileprotic drugs after regular treatment for two or three years. It is advisable that the doctor in clinical charge of such a patient should consult with a member of the Panel of Leprosy Opinion before deciding to cease treatment. After a further period of observation—usually three or four years—removal from the Central Register of Leprosy may be recommended, normally by a member of the Panel of Leprosy Opinion or other doctor experienced in leprosy.

Drug resistance

26. Drug resistance is becoming increasingly common. It may be suspected when a patient suffering from lepromatous leprosy, after regular treatment with standard drugs for several years, shows bacteriological and, subsequently, clinical signs of relapse. Morphologically normal bacilli reappear in the nasal mucosa and the dermis. Hence the need for regular (that is, annual) bacteriological examination of such patients after clinical quiescence has been achieved. In a case of suspected resistance, it is recommended that a member of the Panel of Leprosy Opinion should be called in consultation at the earliest opportunity.

Complications

27. The education of the patient who has some degree of motor or sensory deficit will help to prevent much of the damage that results from unappreciated traumata. Similarly, judicious physiotherapy will help to maintain muscle power and preserve useful function, and the services of a chiropodist will reduce the likelihood of ulceration developing in an anaesthetic foot. Established deformities of hands, feet or face, resulting from peripheral nerve damage may require specialised care including splints, prostheses and reconstructive surgery with suitable pre- and post-operative physiotherapy. The help of a knowledgeable orthopaedic surgeon should be enlisted; if necessary the Consultant Adviser in Leprosy to the Department will advise practitioners on these matters.

28. It must be stressed that patients suffering from lepromatous or near-lepromatous leprosy run a continuing risk of serious complications in the eye, particularly an iridocyclitis of insidious and painless onset. It is therefore advisable for such patients to be examined regularly by an ophthalmologist.

Admission to hospital

29. Open or contagious leprosy is present if skin or nasal mucosa smears contain solid-staining bacilli which are presumably viable. All other patients are almost certainly non-contagious. Such patients can be treated effectively at least during the greater part of the course of their disease, while they continue to live in their own homes. If, exceptionally, it is found necessary to recommend admission to hospital for leprosy the duration of stay should be as short as possible.

30. An open case of leprosy, who is living in overcrowded premises or who cannot be relied on to refrain from actions which might expose others to risk of infection, is best admitted to hospital for treatment, and kept in

hospital for as long as he is discharging viable bacilli from the nose. It is advisable to treat all children with open leprosy as in-patients until they can be regarded as no longer potentially infective. Unless alternative local arrangements already exist, patients requiring in-patient treatment for leprosy or for any acute complications of leprosy can be admitted to the Hospital and Homes of St. Giles, East Hanningfield, near Chelmsford, Essex, by prior arrangement with Dr. S. G. Browne, CMG, OBE (Tel. No. 01-935 5848).

31. Facilities for in-patient treatment are also available at the Hospital for Tropical Diseases (4 St. Pancras Way, London NW1, Tel. No. 01-387 4411), and at the Slade Hospital, Oxford (Tel. No. 0865 64841).

32. Where necessary, patients who have been receiving treatment for leprosy and who are no longer considered to be infectious may be admitted to the wards of a general hospital. No special precautions need to be observed. However, it should be appreciated that surgical intervention, or the administration of drugs such as cortico-steriods, may result in an exacerbation of leprosy or a reactivation of the disease. For this reason it is desirable that, when a leprosy patient is admitted to hospital for a complaint other than leprosy, a member of the Panel of Leprosy Opinion should be consulted.

Prevention and control of leprosy in England and Wales

33. The best way of controlling leprosy at present known is to ensure that patients suffering from leprosy have adequate treatment for as long a period as necessary, so that they become unable to transmit the disease to others.

Examination of contacts

34. Ideally, all those who have been closely exposed to a patient suffering from leprosy—especially the multibacillary types (lepromatous or borderline), and in particular where the source case has been untreated for some time or inadequately treated—should be examined every three months or so for several years. This applies particularly to children and to adults who share the same sleeping quarters as the patient. The whole skin should be examined in a good light by a doctor conversant with the early signs of leprosy in the skin. These changes in the skin may appear at any time from two to five years after exposure; they are generally symptomless and non-specific.

35. In this country, however, the possible value of the regular examination of contacts over several years in disclosing signs of early leprosy must be set against the possible alarm and psychological trauma, the emotional publicity, and the risk of a breach of confidentiality and confidence. Each case, therefore, must be judged on its merits, in the knowledge that leprosy is rarely contracted even after such close contact with an index case as in marriage. All close (that is, household) contacts should in general be advised to report at once any suspicious skin condition. If any rash occurs in such a contact, a consultant in dermatology should be called in and, if thought necessary, a member of the Panel of Leprosy Opinion.

Prophylaxis

36. The evidence at present available suggests that BCG vaccination will enhance any existing innate potential resistance to leprosy challenge. For this reason, and because of its protective value in tuberculosis, it should be offered to any child or young adult (not strongly tuberculin-positive) who has been in close contact with a patient suffering from leprosy.

37. Dapsone given prophylactically for a lengthy period to persons having been in close contact with a case of infectious leprosy will also probably confer some protection against the development of clinically recognisable disease. Hence prophylactic dapsone should be recommended to those considered to have been at real risk because of prolonged and intimate contact with a person who had been shedding viable leprosy bacilli before diagnosis. The expert assistance of a member of the Panel of Leprosy Opinion in this respect would be helpful.

The usual oral prophylactic dose of dapsone is as follows:—

Up to 4 years	25mg. per week
4 to 7 years	50mg. per week
7 to 12 years	75mg. per week
12 to 15 years	100mg. per week
Over 15 years	200mg. per week

in divided doses.

Control

38. Responsibility for the control of leprosy lies with the Medical Officer for Environmental Health of the local authority district who is recommended to consult a member of the Panel for help in any case where he is concerned about the public health aspects of management. In cases of difficulty, the Consultant Adviser and/or the DHSS Division of Communicable Disease and Public Health (Tel. No. 01-407 5522)* are also available to advise.

Health Education

39. Misunderstandings and irrational fears about leprosy are common in the community. The following basic facts about leprosy need to be made clear to patients, their relatives and friends:—

(1) Leprosy is normally a curable disease caused by an easily identifiable bacillus.

(2) It is only slightly contagious and most people are, to some extent, naturally immune to the disease.

(3) If it is treated early enough, it can be arrested without deformity or stigmata.

*In Wales, the Medical Officer Welsh Office (Environmental Health and Infectious Diseases, Tel. No. 0222 44151).

(4) Only a few people need to continue treatment for life.

(5) Leprosy is slow to develop and takes considerable time to treat. It affects different people in different ways.

(6) Patients with leprosy who are undergoing treatment for leprosy can live at home, continue normal family life, work and attend hospital out-patients or be admitted to a general hospital ward while under treatment (but see paragraph 32).

Central Register of Leprosy

40. Medical Officers for Environmental Health have been asked (CMO 1/66) to keep a strictly confidential record of persons suffering from leprosy in their districts. They are also required (paragraph 6(3) of the Public Health (Infectious Diseases) Regulations, 1968)* to send a copy of the original notification to the Chief Medical Officer.

Cases of leprosy so reported to the Chief Medical Officer are registered in the Central Register which is maintained by the Department of Health and Social Security. Each patient is allotted a Central Register serial number. Details such as the patient's address, the type of leprosy and the state of the disease are entered in the Register. Medical Officers for Environmental Health are requested to inform the Department during the year of those leprosy patients removing into or out of the district, dying or emigrating. Any major change in the state of disease of a patient should also be reported. (Doctors in clinical charge of leprosy patients should be asked to keep the MOEH fully and punctually informed of these changes.) A patient's name is kept on the Register until his disease is declared by his doctor to be arrested, or when he emigrates or dies.

Annual Review

41. In order that the Central Register of Leprosy can be maintained accurately, Medical Officers for Environmental Health are asked to undertake, at the beginning of each year, a review of patients with leprosy domiciled in their district, including those who are receiving hospital in-patient treatment, and to forward a return, under confidential cover, to the Chief Medical Officer. The return should include the name, address and Central Register serial number of each such patient together with other relevant information on the present state of the patient's disease (see below), the development of sequelae, remedial treatment with an antileprotic drug (for example, dapsone, rifampicin, thiambutosine, clofamzimine.

42. To make the annual returns more useful, Medical Officers for Environmental Health are asked in future to classify the state of the patient's disease as follows:—

*As amended by the Public Health (Infectious Diseases) (Amendment) Regulations 1974.

Patients to remain on the Register

(a) Active and infectious (A.I.): This term is restricted to those leprosy patients who are known to be discharging viable leprosy bacilli (usually from the nasal mucosa).

or (b) Active but non-infectious (A.NI.): This category comprises all patients with active disease who are considered to be non-infectious.

or (c) Quiescent (Q): All patients whose disease is no longer active. This would include patients who, having suffered from lepromatous or borderline leprosy (i.e., all cases of multi-bacillary leprosy) which has now become quiescent, have been advised to continue treatment to prevent relapse.

Patients returned as '*removed from the Register*' should be detailed as:—

Disease arrested (C) i.e., no longer requiring medical treatment or surveillance.

or Patient died (D).

or No longer resident in this country (E).

43. Surveillance via the Central Register has proved to be of considerable value in following the epidemiology of leprosy in this country. It is for this reason that the continuing co-operation of clinicians, Medical Officers for Environmental Health, and members of the Panel of Leprosy Opinion is much appreciated.

Panel of Leprosy Opinion

Name	*Address*	*Telephone No.*	*Preferred area of consultation*	*Remarks*
Dr. S. G. Browne, CMG, OBE	57A Wimpole Street, London W1M 7DF	01–935 5848 or 01–935 6071	As at request of members of Panel	
Dr. A. D. M. Bryceson	Hospital for Tropical Diseases, 4 St. Pancras Way, London NW1 0PE	01–387 4411	London and the Home Counties	Will go further afield if necessary
Dr. T. F. Davey, CBE	12 Garland Avenue, Emsworth, Nr. Portsmouth, Hants PO10 7QA	02434 3672	Portsmouth and Southern England	
Dr. J. M. B. Garrod	57 Attimore Road, Welwyn Garden City, Herts	043–87 25613	England and Wales	
Prof. H. Gilles	Liverpool School of Tropical Medicine, Pembroke Place, Liverpool L3 5QA	051–709 7611	Liverpool and Manchester areas	
Dr. R. R. M. Harman	Southmead Hospital, Westbury on Trym Bristol BS10 5NB	0272–62 2821	Bristol and South West England	Will go anywhere to see cases if necessary
Dr. W. H. Jopling	Hospital for Tropical Diseases, 4 St. Pancras Way, London NW1 0PE	01–387 4411	London and the Home Counties	
Dr. A. J. Lane	North Western RHA, Gateway House, Piccadilly South, Manchester M60 7LP	061–236 9456 Ext. 456	Lancashire Cheshire, Mersey, Greater Manchester, West Yorkshire, Humberside, North Yorkshire, South Yorkshire	
Dr. C. McDougall	The Slade Hospital, Briscoe Ward, Headington, Oxford OX3 7JH	0865 64841 Ext. 499	Oxford RHA and the Midlands	Prepared to go further afield if adequate notice given
Prof. H. V. Morgan, CBE	Dept of Communicable and Tropical Diseases, East Birmingham Hospital, Bordesley Green East, Birmingham B9 5ST	021–772 4311	Midlands	Will go anywhere to see cases
Dr. C. J. Stevenson	Dept of Dermatology, The Royal Victoria Infirmary, Queen Victoria Road, Newcastle upon Tyne, NE1 4LP	0632 25131 Ext. 2235	Northern RHA area	
Prof. A. W. Woodruff	Hospital for Tropical Diseases, 4 St. Pancras Way, London NW1 0PE	01–387 4411 Ext. 147	—	Will see patients at hospital
Dr. E. H. Wyatt	Dept of Dermatology, Hull Royal Infirmary, Hull HU3 2JZ	0482 28541	Yorkshire RHA	

APPENDIX 11

Summary of patients on the Central Register of Leprosy

Year	Number registered during year	Subsequently removed from Register					Remaining on Register on 31st December 1975			
		Disease arrested	No longer resident in England and Wales	Patient died	Other reasons	Total	Number quiescent	Number still active	Unclassified	Total
1951	48	18	8	15	2	43	5	—	—	5
1952	66	26	13	7	2	48	18	—	—	18
1953	32	12	8	4	2	26	6	—	—	6
1954	31	9	7	4	2	22	8	1	—	9
1955	16	10	2	1	—	13	3	—	—	3
1956	35	17	7	3	1	28	6	1	—	7
1957	29	12	8	2	1	23	6	—	—	6
1958	46	19	13	4	2	38	7	1	—	8
1959	36	18	14	—	1	33	3	—	—	3
1960	38	15	9	4	1	29	9	—	—	9
1961	56	28	10	2	—	40	15	1	—	16
1962	42	15	8	4	2	29	13	—	—	13
1963	40	20	6	2	1	29	10	1	—	11
1964	63	26	17	1	2	46	16	1	—	17
1965	50	19	7	5	3	34	14	2	—	16
1966	55	21	10	1	1	33	19	2	1	22
1967	49	18	8	1	—	27	18	4	—	22
1968	45	12	9	2	—	23	14	8	—	22
1969	31	9	4	1	—	14	6	11	—	17
1970	34	6	7	2	—	15	6	12	1	19
1971	41	8	7	2	—	17	7	17	—	24
1972	29	2	7	1	—	10	6	12	1	19
1973	39	1	3	2	1	7	11	20	1	32
1974	35	—	5	—	3	8	16	10	1	27
*1975	20	—	1	—	—	1	12	6	1	19
TOTAL	1,006	341	198	70	27	636	254	110	6	370

*18 new cases added to the Register in 1976 (up to November). Total to date—1,024.

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