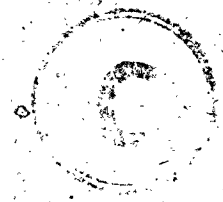


Report of Leprosy
Commission in India 1890-91

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LEPROSY IN INDIA.

REPORT

OF THE

LEPROSY COMMISSION IN INDIA,

1890-91.

CALCUTTA:

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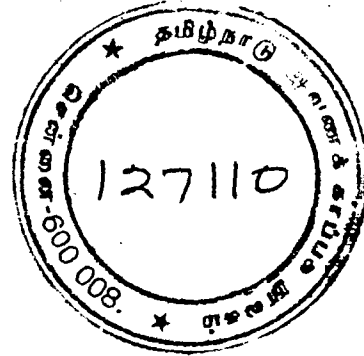
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CALCUTTA:
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In Memoriam.

ARTHUR BARCLAY died at Simla on August the 2nd, 1891. With deep regret his colleagues take this opportunity to express their sense of the great loss they have sustained in the death of one who was both their Friend and Fellow-worker.

* செப்பனிடுவதற்காக எடுத்திக *
* கொள்ளப்பட்ட *
* 1979 மாதம் 1989 வருடம் *
* செப்பனிடும் முடித்த *
* 1979 மாதம் 1989 வருடம் *
* *
* ஆராய்ச்சி உதவியாளர் *
* கையொப்பம் *

INTRODUCTION.

IN April 1889 Father Damien de Veuster died of leprosy at Molokai. Born in Belgium, he had left his native country sixteen years before, and from that time had devoted himself to the relief of the Hawaiian lepers.

His martyrdom did not appeal in vain to humanity, and a Committee was at once formed in England to consider the best way of perpetuating his memory. The first meeting of this Committee was held at Marlborough House on June 17th, 1889, under the presidency of H. R. H. the Prince of Wales.

An Executive Committee was next nominated, which, at a meeting on June 30th, resolved on the erection of a memorial to Father Damien at Molokai, the formation of a fund for indigent British lepers in the United Kingdom, the endowment of two Leprosy Studentships, and finally the appointment of an Indian Leprosy Commission.

Subscriptions were raised, and the sum collected was further increased at a dinner, on January 13th, 1890, at the Hôtel Métropole. The chair was taken by H. R. H. the Prince of Wales, who, in proposing the toast of the evening, gave an account of the National Leprosy Fund and invited further subscriptions.

Subsequently a letter was received from the Government of India expressing their willingness to subscribe to the fund, and to assist by appointing two Indian delegates to act with the British Commissioners, and by facilitating in every way the collection of evidence by the Commission throughout India.

Three Commissioners were appointed by the Royal College of Physicians, the Royal College of Surgeons, and the Executive Committee of the National Leprosy Fund respectively. A special Committee was also formed to prepare instructions for the Leprosy Commission. In accordance with these instructions the Commissioners left London on October 23rd, 1890, and arrived on November 17th at Bombay, where they were met by the Indian representatives. A full account of the further proceedings of the Commission will be found in the diary.

It only remains to record the great interest shown in the work of the Commission and the invaluable assistance afforded by Their Excellencies the Viceroy of India, and the Governors of Bombay and Madras, by Their Honours the Lieutenant-Governors of Bengal, the North-Western Provinces and Oudh, and the Punjab, and by the Chief Commissioners of the Central Provinces, Assam, and Burma.

For help in carrying out the more technical part of the work special thanks are due to Dr. Rice, Surgeon-General with the Government of India, and to

Drs. Pinkerton and De Fabeck, Surgeons-General with the Governments of Bombay and Madras respectively.

Finally, the Commissioners must express their appreciation of the great kindness shown them throughout the country by the Civil Surgeons and Missionaries, who spared no trouble in rendering every possible assistance. To the Managers of the Railway Companies also the sincere thanks of the Commission are due for their unfailing courtesy.

Method of Working.

The following plan of procedure was agreed upon. The first aim of the Commissioners was to acquaint themselves with the features of the disease as it appears in the Empire, directing their attention more to ætiological factors than to purely clinical aspects. This could only be done by travelling from centre to centre, and from asylum to asylum, and personally enquiring into the histories of as large a number of lepers as possible. It was, therefore, decided to take full advantage of the cold season, and to spend about five months in examining asylums and lepers in various localities. Subsequently the Commissioners were to assemble at some hill station in order to supplement their enquiries by pathological and bacteriological researches.

Numerous places were visited, and over two

thousand lepers were personally examined with a view to eliciting certain data as to heredity, contagion, and other points in the ætiology of the disease. This portion of the enquiry occupied exactly five months, and the remainder of the time was devoted to bacteriological investigations at Simla, where the Indian Government had built a laboratory for the use of the Commission.

Questions were also sent through the Office of the Surgeon General with the Government of India to all Civil Surgeons with a view to obtaining their personal opinions, and gaining information regarding the distribution and spread of the disease and allied general questions.

The Report.

The report is thus divided into two chief parts. In the first the results of the enquiry by the Commission while travelling will be considered; the second part will give an account of their laboratory work.

The first chapter will contain a short diary, and this will be followed by a description of the asylums and districts visited, the number of lepers seen, and other statistical information. Details of the distribution and spread of leprosy and its relation to soil, climate, race, and other conditions will next be discussed, while the following two chapters will treat of the all-important questions of heredity and contagion.

The sixth chapter will be devoted to such ætiological points as food, syphilis, and defective hygiene. A brief summary of the various methods of treatment hitherto employed, and the deductions based on the enquiry of the Commissioners, will conclude the report. In an appendix an account of the pathological and experimental work done at Simla and Almora will be given.

GENERAL REMARKS.

THE ordinary clinical aspects of leprosy are too well known to require notice here. It will be sufficient to state that in India, as in other parts of the world, three forms of leprosy are met with, the tuberculated, the anæsthetic, and the mixed. In the first the skin is primarily invaded by the leprous growth, afterwards the mucous membranes and viscera. In the second form the lesions occur chiefly in the peripheral nerves, while the third is simply a combination of the other two forms.

It has been suggested by some observers that tuberculated and anæsthetic leprosy are distinct diseases. That they are one and the same may be inferred from the fact that tuberculated leprosy is nearly always associated in its later course with anæsthesia, thus giving rise to mixed leprosy, and also from the fact that the same bacillus is found in the two forms. Further, Gerlach¹ has shown by a series of elaborate dissections in a case of anæsthetic leprosy, that the primary growth takes place in the skin around the peripheral ends of the nerves, extending afterwards up the branches to the main trunks. The onset of the disease would thus appear to be the same in each variety.

The following table shows the number of cases and the percentage of each form of leprosy observed by the Commission in the various places visited. These figures agree very nearly with those worked out by Vandyke Carter for Bombay.

(1) Untersuchungen über die Unabhängigkeit der Bildung anästhetischer Hautflecke von der Erkrankung zugehöriger Nerven bei der Lepra anæsthetica Dorpat, 1890.

TABLE I.

Cases observed according to Form of Disease.

ASYLUM OR LOCALITY.	Anaesthetic.	Tubercular.	Mixed.	Disease not stated.	TOTAL.	REMARKS.
Agra . . .	38	1	15	...	54	
Aligarh . . .	8	1	1	...	10	
Almora . . .	74	2	32	...	108	
Bangalore . . .	49	2	4	...	55	
Belgaum . . .	1	2	...	20	23	
Benares . . .	27	1	4	...	32	
Bombay . . .	135	87	35	2	259	
Burdwan . . .	8	1	12	...	21	
Calcutta . . .	52	6	30	1	89	
Calicut . . .	12	1	13	...	26	
Cawnpore . . .	8	...	2	...	10	
Conjeeveram . . .	8	2	6	2	18	
Darjeeling . . .	2	...	1	...	3	
Dehra Dun . . .	46	4	38	...	88	
Delhi . . .	4	1	6	...	11	
Dharmasala . . .	7	...	5	...	12	
Fyzabad . . .	13	1	3	...	17	
Gwalior . . .	7	...	6	...	13	
Gya . . .	28	4	10	...	42	
Hyderabad . . .	7	3	11	...	21	
Jubbulpore . . .	9	...	6	...	15	
Jummoo . . .	1	...	...	1	2	
Kapurthalla . . .	8	2	...	...	10	
Lahore . . .	...	...	2	...	2	
Lucknow . . .	10	...	3	...	13	
Madras . . .	106	19	57	2	184	
Madura . . .	64	9	36	4	113	
Mandalay . . .	51	21	102	3	177	
Meerut . . .	...	...	...	9	9	

Table I—continued.

Cases observed according to Form of Disease.

ASYLUM OR LOCALITY.	Anaesthetic.	Tubercular.	Mixed.	Disease not stated.	TOTAL.	REMARKS.
Moulmein . . .	12	4	9	...	25	
Nagpur . . .	94	27	52	1	174	
Naini and Allahabad . . .	48	2	16	...	66	
Naini Tal . . .	1	1	...	...	2	
Patiala . . .	7	1	1	...	9	
Peshawar . . .	1	1	...	...	2	
Poona . . .	14	31	...	...	45	
Prome . . .	4	14	12	...	30	
Purulia . . .	57	3	34	5	99	
Rangoon . . .	21	1	40	...	62	
Rawalpindi . . .	37	...	10	...	47	
Sialkot . . .	27	6	6	1	40	
Subathu . . .	34	4	8	...	46	
Tanjore . . .	9	2	5	...	16	
Tarn Taran . . .	103	2	36	5	146	
Thayetmyo . . .	23	11	28	...	62	
Trichinopoly . . .	9	2	3	2	16	
Umballa . . .	21	1	10	...	32	
Yerrowda Prison . . .	5	1	9	...	15	
TOTAL . . .	1,310	284	719	58	2,371	
Percentage . . .	56.6	12.2	31.0	...	...	

The age of the patient and the duration of the disease were noted in nearly every case of leprosy examined by the Commission. The patient's age at the onset of the disease was thus easily calculated, and the results are given in Table II arranged in quinquennial periods.

It will be seen from this table that most persons became

lepers between the ages of twenty-six and thirty, the next most frequent time of onset was from twenty-one to twenty-five years of age, then from sixteen to twenty. From such a table it would appear that leprosy most commonly begins between the ages of sixteen and thirty, in other words, in early adult life.

These figures again closely agree with those given by Vandyke Carter.² However a difference does exist. For according to his table 4·7 per cent. acquired the disease before the age of ten, whereas the Commissioners found that according to the information they obtained, about double that percentage were attacked before the age mentioned.

TABLE II.

Ages at which Leprosy appeared, arranged in Quinquennial Periods.

Asylum or Locality.	5 years or under.	6-10.	11-15.	16-20.	21-25.	26-30.	31-35.	36-40.	41-45.	46-50.	51-55.	56-60.	61-65.	66-70.	71-75.	76-80.	81-85.	TOTAL.	Age not stated.	GRAND TOTAL.
Agra	...	...	1	5	9	14	2	9	3	7	1	...	...	...	...	...	...	54	3	57
Aligarh	1	...	1	...	2	1	2	1	1	1	...	...	...	...	...	...	...	10	...	10
Almora	1	12	16	23	20	12	10	9	3	...	2	...	...	...	...	...	...	108	...	108
Bangalore	2	3	1	2	6	9	7	7	3	1	1	2	1	...	1	...	...	46	9	55
Belgaum	1	1	...	...	2	1	1	...	...	...	...	...	...	...	...	...	...	6	17	23
Benares	...	1	1	3	4	7	2	3	2	2	1	1	...	...	...	...	...	33	...	33
Bombay	7	13	18	33	41	35	49	25	16	11	5	5	1	...	...	...	...	253	1	254
Burdwan	...	...	...	4	3	5	3	1	4	1	...	...	...	...	...	...	...	21	...	21
Calcutta	3	5	6	12	3	15	...	3	2	1	1	...	1	...	...	...	...	80	9	89
Calicut	...	...	2	6	3	10	1	1	2	...	...	...	...	...	...	...	...	25	1	26
Cawnpore	...	...	...	1	2	3	1	1	2	...	...	...	...	...	...	...	...	10	...	10
Conjeveram	...	...	2	2	1	5	2	1	...	...	...	...	...	...	...	...	...	13	5	18
Darjeeling	...	...	1	...	1	...	1	...	...	...	...	...	...	...	...	...	...	3	...	3
Dehra Dun	...	3	6	14	7	18	13	10	8	7	1	1	...	...	...	...	...	83	...	83
Delhi	...	...	1	1	2	...	1	...	3	...	1	1	1	...	...	...	...	11	...	11
Dharmasala	1	1	...	...	1	5	3	...	1	...	...	...	...	...	...	...	...	12	...	12
Fyzabad	...	...	...	6	1	2	3	...	...	...	...	...	...	...	...	...	...	17	...	17
Gwalior	...	...	3	1	2	1	1	...	3	1	...	...	...	...	...	...	...	12	1	13

(²) Leprosy and Elephantiasis, page 152.

Table II—continued.

Ages at which Leprosy appeared, arranged in Quinquennial Periods.

Asylum or Locality.	5 years or under.	6-10.	11-15.	16-20.	21-25.	26-30.	31-35.	36-40.	41-45.	46-50.	51-55.	56-60.	61-65.	66-70.	71-75.	76-80.	81-85.	TOTAL.	Age not stated.	GRAND TOTAL.
Gya	...	2	2	5	4	7	8	7	5	...	...	1	1	...	...	...	...	42	...	42
Hyderabad	...	1	2	5	3	1	3	1	...	2	...	...	...	...	...	...	...	18	3	21
Jubbulpore	...	...	...	1	4	...	1	3	2	1	2	...	1	...	...	...	...	15	...	15
Jummoo	...	...	...	1	...	...	...	...	1	...	...	...	...	...	...	...	...	1	...	1
Kapurthalla	...	...	2	2	2	1	2	1	...	...	...	...	...	...	...	...	...	10	...	10
Lahore	...	...	...	1	...	...	...	...	...	...	1	...	...	...	...	...	...	1	...	1
Lucknow	...	...	...	2	3	2	1	2	1	1	...	...	...	...	...	...	...	11	1	12
Madras	10	21	25	23	30	26	14	14	12	4	9	1	2	...	...	2	...	182	2	184
Madura	3	13	16	15	15	17	9	7	5	7	1	1	...	...	...	...	...	113	1	114
Mandalay	3	17	36	38	33	16	10	10	5	6	1	...	...	...	1	...	...	175	2	177
Meerut	...	1	1	1	3	2	1	...	...	...	...	...	...	...	...	...	...	9	...	9
Moulmein	3	4	2	5	3	6	...	2	...	...	...	...	...	...	...	...	...	25	...	25
Nagpur	1	12	13	13	21	25	21	22	13	7	1	1	...	3	...	...	...	164	10	174
Naini and Allahabad	...	1	4	3	9	15	9	8	4	8	2	...	...	2	...	...	...	65	1	66
Nami Tal	...	...	1	...	...	1	...	...	...	...	...	...	...	...	...	...	...	2	...	2
Patiala	...	...	4	2	...	...	...	2	...	...	1	...	...	...	...	...	...	9	...	9
Peshawar	...	...	...	1	...	...	...	...	...	...	...	...	...	...	...	...	...	1	1	2
Poona	5	2	2	1	4	7	6	4	4	6	2	1	...	1	...	...	...	45	...	45
Prome	...	7	3	5	3	1	3	3	2	2	1	...	...	...	...	...	...	33	...	33
Porolia	...	...	4	4	13	14	12	18	7	7	3	2	...	...	...	...	...	83	16	99
Rangoon	1	3	10	9	12	8	7	6	4	2	...	...	...	...	...	...	...	62	...	62
Rawalpindi	3	4	5	7	11	7	2	4	...	2	...	1	...	...	1	...	...	47	...	47
Sialkot	1	3	7	2	6	9	1	4	2	3	...	1	...	...	...	...	...	39	1	40
Subatha	...	3	4	4	4	5	10	8	2	3	1	...	...	1	...	...	...	45	1	46
Tanjore	...	2	3	1	...	1	5	1	...	...	...	...	1	...	...	...	...	14	2	16
Tam Taran	3	6	12	17	15	25	19	13	6	11	3	...	...	...	...	...	...	140	6	146
Thayetmyo	...	8	11	5	15	6	4	5	4	2	1	...	...	...	...	...	...	61	1	62
Trichinopoly	...	...	1	1	2	5	4	...	...	1	...	...	...	...	...	...	...	14	2	16
Umballa	...	1	4	3	2	5	3	3	4	1	1	2	...	2	...	...	...	31	1	32
Yarrowda Prison	...	...	1	3	3	3	1	1	1	...	...	...	...	...	...	...	...	13	2	15
TOTAL	49	151	244	293	333	358	266	230	158	111	45	24	8	11	3	...	2	2,272	99	2,371

In Table III the actual ages of the lepers at the time they were seen are given. This table does not materially differ from the last one, for it was remarked by the Commission that most of the lepers examined by them had been afflicted for several years. If then all the figures in this table are put back five or ten years, they will be found to approach closely those in Table II.

TABLE III.

Cases observed according to Actual Ages in Quinquennial Periods.

Asylum or Locality.	5 years or under.	6-10.	11-15.	16-20.	21-25.	26-30.	31-35.	36-40.	41-45.	46-50.	51-55.	56-60.	61-65.	66-70.	71-75.	76-80.	81-85.	86-90.	91-95.	96-100.	TOTAL.	Age not stated.	GRAND TOTAL.
Agra	1	5	8	4	8	5	12	1	6	1	...	...	...	...	...	...	...	...	...	...	51	3	54
Aligarh	1	...	...	1	3	1	2	1	1	...	...	...	...	...	...	...	...	...	...	...	10	...	10
Almora	1	3	8	12	25	11	21	10	9	3	5	...	...	...	...	...	...	...	...	...	108	...	108
Bangalore	1	...	2	8	5	12	4	5	2	4	...	2	...	...	1	...	...	...	...	...	50	5	55
Belgaum	1	...	2	...	3	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	6	17	23
Benares	1	3	5	7	2	4	1	7	1	...	...	...	...	...	...	...	...	...	...	...	34	...	34
Bombay	4	7	27	37	50	44	22	23	5	12	7	2	1	...	...	...	...	...	...	...	259	...	259
Burdwan	...	...	3	3	5	5	1	4	...	...	...	...	...	...	...	...	...	...	...	...	21	...	21
Calcutta	5	5	7	13	8	17	3	15	3	2	3	...	1	...	...	...	...	...	...	...	80	9	89
Calicut	1	...	4	8	6	5	1	1	1	...	...	...	...	...	...	...	...	...	...	...	25	1	26
Cawnpore	...	1	6	...	1	1	1	...	...	...	...	...	...	...	...	...	...	...	...	...	10	...	10
Coimbatore	1	1	1	3	5	4	2	...	...	...	...	...	...	...	...	...	...	...	...	...	18	...	18
Darjeeling	1	1	1	1	1	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	3	...	3
Dehra Dun	1	2	5	10	17	11	15	11	9	5	2	...	...	...	...	...	...	...	...	...	68	...	68
Delhi	1	1	1	3	...	2	2	1	1	...	3	...	...	...	...	...	...	...	...	...	11	...	11
Dharmasala	1	1	1	3	3	2	1	1	...	...	...	...	...	...	...	...	...	...	...	...	12	...	12
Fyzabad	1	1	4	4	2	3	1	...	...	...	...	...	...	...	...	...	...	...	...	...	17	...	17
Gwalior	2	2	1	1	2	...	3	...	...	...	...	...	...	...	...	...	...	...	...	...	10	...	10
Gya	1	1	3	4	5	5	5	5	5	5	2	...	...	...	...	...	...	...	...	...	43	...	43
Hyderabad	3	5	1	4	2	2	...	3	2	...	...	...	...	...	...	...	...	...	...	...	21	...	21
Jubbulpore	1	2	...	4	...	4	1	2	...	...	...	...	...	...	...	...	...	...	...	...	15	...	15
Jumna	1	...	1	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	2	...	2
Kaparthalla	2	2	3	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	10	...	10
Lahore	1	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	2	...	2
Lucknow	1	3	4	1	3	1	...	...	...	...	...	...	...	...	...	...	...	...	...	...	13	...	13
Madras	7	25	31	25	31	13	14	13	11	3	3	...	...	...	...	...	...	...	...	...	134	...	134

Table III—continued.

Cases observed according to Actual Ages in Quinquennial Periods.

Asylum or Locality.	5 years or under.	6-10.	11-15.	16-20.	21-25.	26-30.	31-35.	36-40.	41-45.	46-50.	51-55.	56-60.	61-65.	66-70.	71-75.	76-80.	81-85.	86-90.	91-95.	96-100.	TOTAL.	Age not stated.	GRAND TOTAL.
Madura	1	13	11	18	17	9	13	11	10	6	4	...	...	...	...	...	...	...	...	...	113	...	113
Mandalay	1	9	35	34	31	13	19	15	10	6	1	1	...	1	1	...	...	...	...	...	177	...	177
Meerut	...	...	...	1	1	3	...	3	1	...	...	...	...	...	...	...	...	...	...	...	9	...	9
Moulmein	1	3	6	3	10	...	2	1	...	1	...	...	...	...	...	...	...	...	...	...	25	...	25
Nagpur	1	7	16	21	27	13	27	12	20	5	4	1	1	2	...	...	...	...	...	...	167	7	174
Naini and Allahabad	1	1	10	8	7	12	5	3	3	3	...	2	...	...	...	...	...	...	...	...	55	1	65
Naini Tal	1	...	...	...	1	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	2	...	2
Patna	...	...	3	...	2	...	1	2	...	1	...	...	...	...	...	...	...	...	...	...	9	...	9
Peshawar	...	...	...	1	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	1	1	2
Poona	2	2	3	...	5	6	9	2	7	1	5	2	...	1	...	...	...	...	...	...	45	...	45
Prome	3	2	3	6	5	2	2	...	4	3	2	...	...	...	...	...	...	...	...	...	30	...	30
Putna	1	1	3	3	11	15	18	16	12	1	3	...	...	...	...	...	...	...	...	...	37	12	49
Rangoon	2	6	11	16	10	10	6	6	1	...	...	...	...	...	...	...	...	...	...	...	62	...	62
Rawalpindi	2	...	8	6	9	13	...	5	...	2	...	...	...	2	...	...	...	...	...	...	47	...	47
Saikat	1	...	5	7	2	5	2	9	1	3	...	4	...	1	...	...	...	...	...	...	30	1	40
Sebatini	1	1	8	5	7	3	5	4	5	1	...	...	1	...	...	...	...	...	...	...	46	...	46
Tanjore	5	...	11	2	4	1	...	...	...	...	...	...	...	1	...	...	...	...	...	...	14	2	16
Tarn Taran	1	1	3	7	12	8	37	15	15	2	21	2	2	...	...	...	...	...	...	...	143	3	146
Thayetmyo	1	6	7	8	12	6	6	7	5	1	1	...	1	...	...	...	...	...	...	...	61	1	62
Trichinopoly	1	1	...	5	4	2	2	1	...	...	...	...	...	...	...	...	...	...	...	...	15	...	15
Umbaia	2	2	7	...	4	1	5	1	3	...	5	...	1	...	...	...	...	...	...	...	31	...	32
Yarrowda Prison	5	1	1	4	1	1	...	...	...	...	...	...	...	...	...	...	...	...	...	...	13	2	15
Total	3	19	75	180	157	345	297	390	265	262	32	137	23	22	5	9	1	...	1	1	2,365	56	2,371

In the foregoing tables the sexes have not been separated, as in consequence of the conditions of life in India few adult women were seen, and it seemed hardly fair to calculate any relative percentage of sexes.

It was thought, however, that some conclusions might be drawn from those cases in which the disease began before the age of ten, for up to this time females are not secluded.

in diagnosis made by native enumerators and others entrusted with reporting or collecting cases of leprosy. In each place visited a record was therefore kept of all negative and doubtful cases appearing amongst the patients collected for examination as lepers. Table V gives the number of negative cases, with short notes of their nature. All doubtful cases have been omitted, for nothing can be argued from them. Two percentages of errors have been worked out, one for all the places visited, and the other for those places only where no leper asylum existed. It is at once evident that the latter is the fairer percentage to adopt, for in these places the diagnostic powers of native police, hospital assistants and others of the class from which the census enumerators would be taken, are chiefly relied on, while in places with a leper asylum the inmates come under the notice of the Civil Surgeon, or at any rate of some qualified medical man, so that spurious cases are more likely to be detected. The difference in the figures is sufficiently obvious, the percentage of errors being 5 for all the places visited, against 9.5 for localities with no leper asylum.

These probably are the most reliable figures obtainable from the data at hand, and it will readily be seen that if a deduction be made, say, of a tenth of all the lepers returned for India, a not inappreciable diminution in the estimated leper population will result.

TABLE V.

Errors in Diagnosis.

ASYLUM OR LOCALITY.	No. of persons produced as lepers.	No. of Negative Cases.	Form of Disease.
Agra	54	...	Syphilis.
Aligarh	(12)	2	
Almora	108	...	

NOTE.—Figures shown in brackets are the cases which were collected by the local authority.

Table V—continued.

Errors in Diagnosis.

ASYLUM OR LOCALITY.	No. of persons produced as lepers.	No. of Negative Cases.	Form of Disease.
Bangalore	63 (33)	8 (7)	(3) Syphilis, (2) Syrosis of the hand, (1) Leukoderma, (1) Chronic Rheumatism, (1) Psoriasis, (1) Old Age.
Belgaum	21	...	
Benares	36	4	(3) Leukoderma, (1) Pityriasis Versicolor.
Bombay	259	...	
Burdwan	(23)	2	(1) Psoriasis, (1) Syphilis.
Calcutta	89	...	
Calicut	27	1	Syphilis.
Cawnpore	(10)	...	
Conjeevaram	(20)	2	(1) Syphilis, (1) Leukoderma.
Darjeeling	(7)	4	(2) Syphilis, (1) Seborrhoea Scala, (1) Eczema of foot.
Dehra Dun	88	...	
Delhi	(12)	1	Syphilis.
Dharmasala	12	...	
Fyzabad	(18)	1	Whitlow on thumb.
Gwalior	(13)	...	
Gya	(44)	2	(1) Syphilis, (1) Ringworm.
Hyderabad	(30)	9	(3) Leukoderma, (1) Perforating Ulcer, (1) Neuritis of Ulnar Nerve, (1) Nil, (1) Phthisis, (2) Nerve lesions.
Jubbulpore	(38)	23	(22) Leukoderma, (1) Syphilis.
Jumunoo	(2)	...	
Kapurthulla	(10)	...	
Lahore	(2)	...	
Lucknow	14	1	Epilepsy.
Madras	189	5	(1) Tabes with perforating ulcer, (1) Acne, (1) Syphilis, (1) Nil.
Madura	(123)	10	(1) Acne, (1) Scaly condition of skin, (1) Syphilis, (1) Numbness in thigh, (1) Pale patch on knee, (1) wasting of interossei of right hand, (1) Mottling of skin, (1) Ichthyosis, (1) Edema of feet and legs, (1) Eczema of toes.

NOTE.—Figures shown in brackets are the cases which were collected by the local authority.

Table V—concluded.

Errors in Diagnosis.

ASYLUM OR LOCALITY.	No. of persons produced as lepers.	No. of Negative Cases.	Form of Disease.
Mandalay . . .	(180)	3	(1) Elephantiasis, (1) Syphilis, (1) Leukoderma.
Moulmein . . .	(26)	1	Lupus Erythematosus.
Nagpur . . .	(188)	14	(3) Syphilis, (3) Leukoderma, (1) Caries of spine, (7) Nil.
Naini and Allahabad . . .	79	13	(1) Leukoderma, (1) Syphilis, (1) Malingering, (1) Lupus of face, (7) Nil.
Naini Tal . . .	(2)	...	
Patiala . . .	(9)	...	
Peshawar . . .	(2)	...	
Poona . . .	45	...	
Prome . . .	(32)	2	(1) Ringworm, (1) Leukoderma.
Parulia . . .	101	2	(1) Syphilis, (1) Nil.
Rangoon . . .	(66)	4	(2) Syphilis, (2) Leukoderma.
Rawalpindi . . .	48	1	Syphilis.
Sialkot . . .	40	...	
Subathu . . .	46	...	
Tanjore . . .	(20)	4	(1) Ringworm, (1) Leukoderma, (1) Want of Co-ordination in extremities, History of Syphilis, (1) Tertiary Syphilis.
Tarn Taran . . .	146	...	
Thayetmyo . . .	(65)	3	(1) Acne of face, (1) Ringworm, (1) Ulcer and Swelling of Foot.
Trichinopoly . . .	19	3	(1) Scrofulous Ulcer and Cancer of oris (1) Molluscum fibrosum.
Umballa . . .	32	...	(1) Spinal curvature and wasting of interossei.
Yerrowda Prison . . .	15	...	
TOTAL . . .	2,487	125	= 5 per cent.
Total, reckoning only places with no Leper Asylums . . .	987	94	= 9.5 per cent.

NOTE.—Figures shown in brackets are the cases which were collected by the local authority.

The condition known as ainum was more or less marked in several cases examined in India. The pathology of this obscure disease is not yet known. There is no doubt that it may occur either in lepers or in otherwise healthy subjects. When in the latter, however, it nearly always attacks the little toe of one or other foot. In lepers, on the contrary, it may attack any toe or even finger. The following case seen by the Commission at the Matoonga Leper Asylum, Bombay, is typical. A Hindu boy, aged ten years, had suffered from mixed leprosy for three and a half years. On examination the little toe of the left foot was found to be enlarged, the outline convex and the skin thickened and completely anæsthetic. There was a furrow all round the base of the toe. On the plantar, inner and outer aspects, this extended nearly half through the toe, but was shallower on the dorsum. There was a small ulcer on the plantar surface. The toe could be freely moved about, the bone having been absorbed. The skin beyond the furrow was thickened and somewhat painful.

Many of the symptoms of this condition suggest a trophic nerve lesion, but the lesions of ainum are so comparatively mild that little opportunity occurs for *post mortem* dissection of the nerves supplying the affected toe or finger. The occurrence of ainum in any individual should, however, always suggest a most careful examination for anæsthesia and other leprosy symptoms.

Probably few diseases have been so profitable to charlatans as leprosy. While travelling the Commission met with several instances of the credulity of patients in this respect. The acknowledged incurability of the disease, in spite of the attention it has attracted for so many centuries, is no obstacle to the unfortunate leper, who will often spend all his substance on some hakim or other pretender who has promised to restore him to health. The subject of palliative treatment will be considered in another place.

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REPORT
OF
THE LEPROSY COMMISSION.

CHAPTER I.

Diary of the Commission.

THE English members of the Commission left London, October 23rd, 1890, arrived at Bombay, November 17th, and remained, here with the two Indian delegates until November 26th.

November 20th.—The Commissioners visited the Matoonga Leper Asylum, accompanied by Surgeon-Major K. R. Kirtikar and Dr. Choksy, the Medical Superintendent of the Asylum, to both of whom they are greatly indebted for much valuable assistance.

November 22nd.—The Trombay Leper Asylum, in the neighbourhood of Bombay, was inspected, the above gentlemen again kindly acting as guides.

November 25th.—A visit was paid to the Dharmsala, a building in the city set apart for indigent lepers.

November 26th.—The Commission then left for Poona, where, on November 28th, they examined the lepers at the David Sassoon Infirm Asylum.

November 29th.—Proceeding thence to Belgaum, the two Asylums were visited, Surgeon-Major J. P. Greany assisting the Commission.

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November 30th.—Returning to Poona they went over the leper ward at the Yerrowda Central Prison.

Accepting a most courteous invitation from the Government of His Highness the Nizam, the Commissioners proceeded to Hyderabad, where they stayed from the 4th to the 10th December. Here they enjoyed the liberal hospitality of Surgeon-Major E. Lawrie, who spared no trouble in assisting them in every possible manner. The Commissioners consider it their pleasant duty once more to give expression to their deep sense of gratitude for all the kindness received while guests at Hyderabad.

Lepers were examined at the hospital and the house of Abdul Gafur, a charitable native gentleman who offers alms and food to the infirm on certain specified days of the week. Lepers from the Central Gaol and from among the native troops were also seen.

December 12th.—From the 12th to the 14th of December the large Asylum at Madras occupied the entire attention of the Commissioners. Surgeon-Major H. D. Cook, under whose direction the Asylum is placed, rendered invaluable services to the Commission not only during their stay at Madras, but at all times.

December 15th.—Conjeeveram was next visited and a certain number of lepers who had been collected at the dispensary were examined.

December 16th.—Travelling through the Madras Presidency, Trichinopoly was reached on December 16th, where, assisted by Brigade-Surgeon W. S. Fox, the Commissioners examined the lepers at the Municipal Leper Hospital.

December 19th.—Tanjore was visited on the 19th of December where Surgeon-Major H. A. F. Nailer had brought together a number of lepers, who were seen and interrogated at the Civil Hospital.

December 20th.—The Commission arrived at Madura and were here met by Surgeon-Major W. B. Browning, from whom

they received great kindness and hospitality. As there was no Asylum at Madura, Dr. Browning had collected a large number of lepers from the town and outlying villages and did everything in his power to facilitate the investigations of his guests.

In accordance with a suggestion made by the Committee in England, it was now considered advisable that the Commission should form two parties, one to travel into Burma, the other to remain in the Peninsula.

December 26th.—The latter—G. A. B., A. B., and A. A. K.—proceeded to Calicut, where they examined the lepers at the Asylum.

January 1st, 1891.—This part of the Commission arrived at Bangalore, where, accompanied by Brigade-Surgeon T. J. McGann, they saw the lepers at the Asylum. Surgeon C. M. Thompson, by the aid of the local authorities, had assembled a number of lepers at a convenient spot in front of the Bowring Hospital, and these also were examined.

January 7th.—Nagpur was reached January 7th. Here Surgeon-Major G. F. A. Harris had made all necessary arrangements and with the aid of the civil authorities a large number of lepers had been assembled at the hospital, and were questioned by the three Commissioners, who take this opportunity of expressing their great obligation to Dr. Harris.

January 14th.—A small number of lepers were seen at the Police Hospital of Jubbulpore. Unfortunately a Hindu festival was in progress, and this prevented the collection of many lepers. Surgeon-Major B. Franklin did everything in his power to assist the Commissioners.

January 16th.—This section of the Commission visited Naini and Allahabad, where they examined the leprous prisoners at the Central Gaol, and the inmates of the Naini Leper Asylum. Thence they proceeded to Calcutta.

December 31st.—B. N. R. and S. J. T. arrived in Rangoon on the 31st of December, and were met by Surgeon-Major

February. Surgeon-Major G. Price of Burdwan and Surgeon J. Sykes of Fyzabad gave him every assistance.

February 23rd to 25th.—Work was continued at Dehra Dun, where Surgeon-Major G. G. Maclaren gave much valuable assistance.

February 1st.—A third section of the Commission—B. N. R. and G. A. B.—left Calcutta on February 1st for Darjeeling, and here Surgeon-Major J. O'Brien gave them every assistance both in collecting lepers and in procuring samples of food eaten by the mixed population of the place.

February 5th.—Returning to Calcutta they travelled to Gya, which was reached on February 5th. Here a number of lepers were examined at the Civil Hospital. The Commissioners take this opportunity of thanking Surgeon-Major R. D. Murray for his kind help and hospitality.

February 10th and 11th.—Benares: Brigade-Surgeon W. R. Hooper had a number of lepers assembled for examination at the Secole Dispensary.

February 13th.—Fyzabad: Here work was done at the Civil Hospital.

February 15th.—Cawnpore: About a dozen vagrant lepers had been collected for the two Commissioners by Brigade-Surgeon J. H. Condon.

February 17th and 18th.—The two Commissioners reached Gwalior, where they were the guests of the Maharaja Scindia. Surgeon-Major A. M. Crofts assisted them in their enquiries.

February 19th.—Agra was reached.

February 23rd.—Aligarh was visited. Surgeon-Major W. H. Cadge kindly collected lepers for examination.

February 25th.—The Commissioners proceeded to Delhi, where they were most hospitably entertained by Surgeon-Major B. Doyle, who assisted them in examining lepers in the city during their stay.

March 2nd.—Peshawar: Surgeon H. Hendley had assembled a few lepers at the Civil Hospital.

March 5th.—The Asylum at Rawalpindi was visited.

March 7th.—The Commissioners saw lepers at the Baba Lakhan Asylum (Sialkot), accompanied by Dr. Dhuni Mehta Chand, who gave them every assistance.

March 8th.—They reached Jummoo, being during their stay the guests of the Maharaja of Kashmir. With Dr. Jaggan Nath, the Civil Surgeon, cases were examined at the hospital.

March 9th.—They arrived at Lahore and conducted their enquiries at the Civil Hospital with the assistance of Brigade-Surgeon W. Center.

March 11th and 12th.—They visited Mooltan, and with Surgeon J. A. Cunningham collected information at the Civil Hospital.

March 15th and 16th.—Accepting an invitation from the Maharaja, a stay of two days was made at Patiala, and by the courtesy of Brigade-Surgeon G. Thomson a number of lepers was examined.

March 17th and 18th.—The Commissioners, through the kindness of the Maharaja, visited Kapurthalla, and with the aid of Surgeon-Major W. P. Warburton, the leper colony in this place was seen and interrogated.

March 19th.—Accompanied by Surgeon G. W. P. Dennys, the Leper Asylum of Umballa was visited.

March 22nd.—These two members reached Almora and here were met by the other Commissioner—S. J. T.—who had returned from Dehra Dun and commenced enquiries. From this date until April 16th, the Asylum was daily visited and notes were taken of the inmates both of the Asylum and the Orphanage.

A large number of lepers was vaccinated and the lymph examined microscopically; specimens of blood, discharges from ulcers, and various excretions and secretions of the body were studied in order to ascertain the distribution of the leprosy bacillus. These and other investigations will be detailed in the

laboratory report. Dr. Carmichael and the Revd. G. H. Bulloch gave every assistance.

April 16th.—Leaving Almora B. N. R. and G. A. B. travelled back to the plains through Naini Tal, where a few lepers were seen at the dispensary. They here take the opportunity of recording the great kindness shown them by Surgeon J. F. Tuohy.

April 27th.—Simla was reached on April 27th, S. J. T. having preceded the other two Commissioners by a few days. Here the united Commission stayed until the completion of their enquiry, engaged chiefly in microscopical and bacteriological work.

CHAPTER II.

Local Notes:—Bengal.

BURDWAN.

NO Asylum exists here. Twenty-three cases were collected and examined at the Civil Hospital and the Gaol. Among this number was one Brahmin. Eighteen lepers were married and had thirty-three children, or 1·8 to each marriage. Five cases had been vaccinated. Two cases that were seen, were not leprosy. Former censuses show that Burdwan is a district where leprosy is exceptionally prevalent, about twenty-five lepers to every ten thousand of the population. According to the census of 1881 the population of this district is 1,391,823, and the number of lepers is stated to be four thousand one hundred and eighteen or 29·5 to ten thousand of the population. The arrival of the Commission at any place frequently caused many lepers to leave the locality. The small number collected here is possibly to be explained in this way.

CALCUTTA.

The Leper Asylum was originally established in 1811. It was situated at Ballygunge, and the buildings accommodated forty persons. After thirteen years, during which time the governors of the Institution attempted by meetings, subscriptions, and applications to Government to enlarge the Institution, but without definite results, the Asylum was moved from Ballygunge to Balliaghatta, and eighty persons could be received into the dwellings. Finally, in 1840, the present Asylum, which is situated in Amherst Street, and stands upon a site given by Government, was erected, the whole Institution being transferred into the city in 1848, and the huts which had been

moved from Balliaghatta were replaced by what are practically the present buildings.

There are at present eighty-nine inmates, the majority of whom are Hindus. Sixty-four are married and have seventy-eight children, giving 1.2 to each marriage. Forty-seven cases had been vaccinated.

Leper Inmates of the Asylum.

	Europeans.	Eurasians.	Native Christians.	Muhammads.	Hindus.	TOTAL.
Males	3	3	5	26	30	67
Females	2	3	3	1	13	22
TOTAL	5	6	8	27	43	89

Among the Hindus there were two Brahmins. Twelve of the cases seen were also suffering from syphilis, and three patients, among whom was one European, were suffering from diseases other than leprosy.

DARJEELING.

Seven cases were examined here, but among these three only were undoubted lepers. Two were married, with three children to each. One case had been vaccinated and one inoculated.¹ It does not appear that leprosy is very prevalent in Sikkim. The consumption of dried fish among the inhabitants as a flavouring is almost universal. Such fish is

(¹) Inoculation for small-pox is still practised to some extent as a protective measure in India, for, as is well known, the mortality from the inoculated disease is much less than from the infective disease, and the form of the disease is milder in the former, than in the latter, case. Material from a small-pox pustule is taken mixed with water and introduced under the skin with a lancet. The site for inoculation is the flexor surface of the forearm (Punjab) or the wrist. This practice is of great antiquity in the East. It was introduced into England from Turkey by Lady Mary Wortley Montague in 1763. During the first quarter of this century it was practised in preference to vaccination. Inoculation for small-pox in England was made illegal by Act of Parliament in 1840.

imported to these hills from Calcutta, and in the bazaar of Darjeeling it is a common article for sale.

GYA.

This is the chief town in the district of Behar. It is a city of pilgrimages, and both here and at Buddh Gya, eight miles distant numbers of lepers were seen in the streets.

Number of lepers per ten thousand of population was 9.8 for 1872 and 9.5 for 1881.

Forty-four cases were examined here, and of this number two were free from leprosy. There is no Asylum, but the Civil Surgeon arranged with the local authorities that lepers should be collected in the compound of the Civil Hospital.

A very large proportion of those who were examined were Beharis, and came from the district.

Thirty-three were Hindus, among these two Brahmins.

Nine were Muhammadans, or 21.4 per cent.

Forty-one were married:

Total number of children born to these was seventy-eight, giving 1.9 to each marriage.

Twenty-six had been inoculated for small-pox.

None had been vaccinated.

Thirteen had suffered from small-pox.

Of twenty-eight cases where enquiries were made, ten had suffered from syphilis.

Diet.—Both Brahmins denied eating fish or meat; butter, milk, dāl, and rice being the chief food.

In nineteen cases enquiries about diet were made, and it was ascertained that—

Five had never eaten fish.

Seven had sparingly eaten fish.

Seven had frequently eaten fish.

Two cases produced were not leprosy.

Enquiries made at Gya showed that the following customs

were followed among the people of this district. Children eat out of the same dish with their father, but the wife never does she only eats after the dish has been washed.

Hindu women do not eat flesh or fish after the death of their husbands.

Many Hindus never eat fish or flesh from childhood.

In lower castes, if the husband leaves any food, the wife will eat it. In higher castes, if the husband leaves food, no person will eat it, but it will be given to the children, or, in the absence of children, to poorer people.

PURULIA.

There is both an Asylum and an Orphanage here. The Revd. H. Uffmann, of the German Evangelical Lutheran Mission, opened the former in February 1888, and the latter in the summer of the same year. There are ninety-nine leper inmates, sixty-one males and thirty-eight females. The sexes are separated. Up to the present time no child has been born in the Asylum. The lepers are attended by a resident native doctor.

Twenty-three children are maintained in a separate compound, which is adjacent to the Asylum. They are all healthy. Three patients who had suspicious symptoms at the time of admission, subsequently became lepers, and were removed to the Asylum. No child, which was originally healthy, has yet become a leper.

Madras.

CALICUT.

The Asylum at Calicut consists of one large well-built bungalow, on the seashore. It has been in existence for more

than thirty years. The Civil Surgeon attends to the inmates. Patients do not receive fish, simply because the diet table of the Asylum was a copy of one used in the Municipal Hospital, where fish is excluded.

A peculiar macular discoloration of the skin is common in the Malabar district. These patches were exceedingly like leprosy, but there was no anæsthesia. Indeed this skin disease has nothing to do with leprosy. Ten or twelve cases seen at the prison simply showed this skin discoloration. Elephantiasis is very common in Calicut. Twenty-seven patients, lepers, were examined here, and among these one case was not leprosy. Of these, twenty-one were married and had forty-eight children, or 2.2 to each marriage. Seven lepers had been vaccinated. One of the servants at the Asylum had contracted leprosy. Fish is a common article of diet in Calicut.

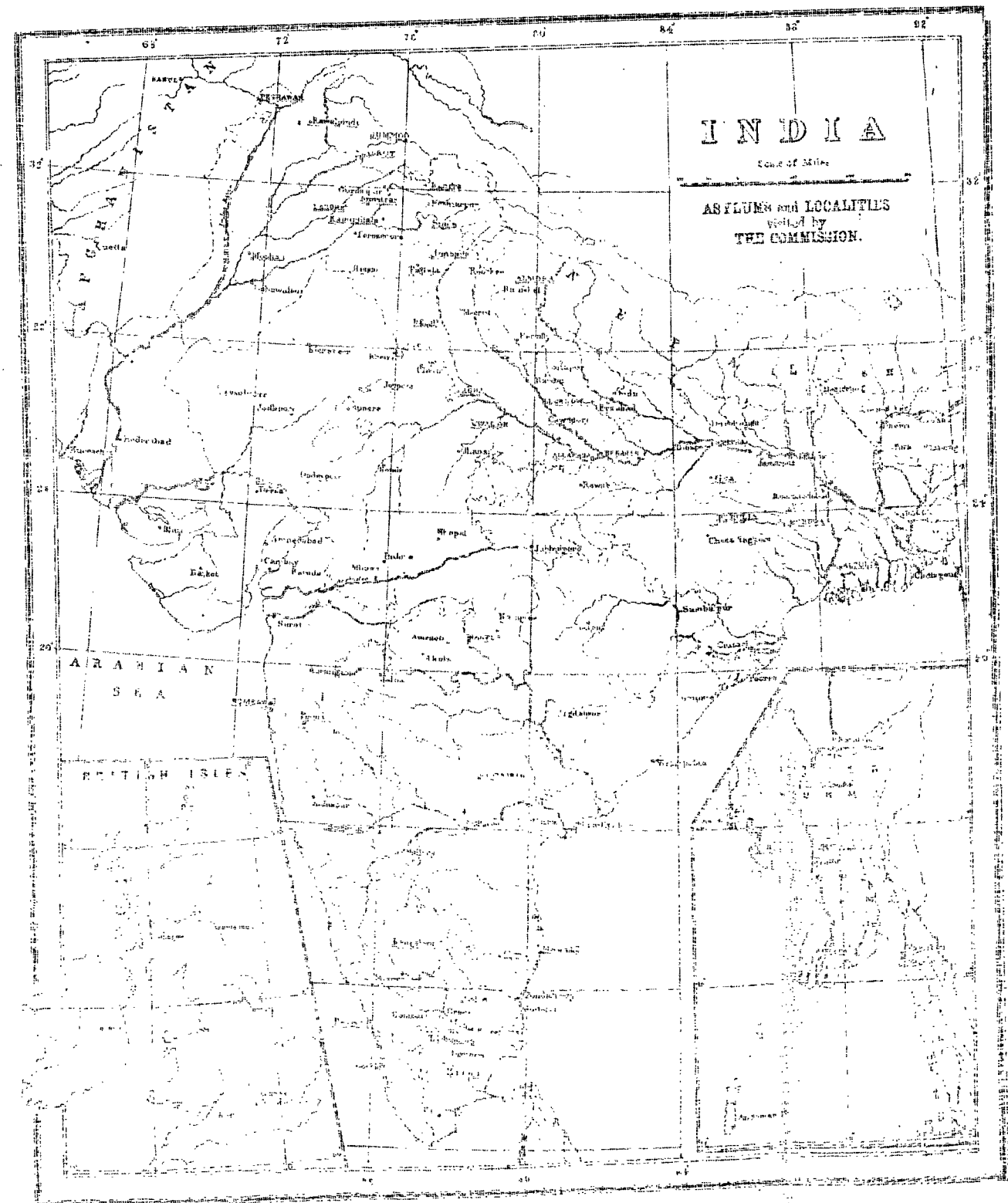
CONJEEVERAM.

The population of Conjeeveram is 37,275, and it is believed that there are about a hundred lepers here. There is no Asylum. Eighteen lepers, all of whom were Hindus, were examined. Among these were many silk weavers. Of this number, thirteen were married. The number of children was forty-two, or 3.2 to each marriage.

As Conjeeveram is one of the seven sacred Hindu cities, a great number of Brahmins live here, some of whom suffer from leprosy. According to enquiries which were made here no fish is eaten by Brahmins, whether they be rich or poor; indeed this rule is rigidly followed. Only in rare cases, where from contact with Europeans a certain degree of education has arisen, is this rule broken.

MADRAS.

The Asylum of Madras consists of a number of bungalows built in a compound situated in Black Town. The garden is



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and in the recently erected Asylum at Matoonga. Numbers of lepers were also seen in the streets of the city. During the present year the inmates of the Trombay Asylum have been transferred to Matoonga. Vagrant lepers, and many from the Dharmasala, are now also in the same Institution.

The Asylum at Trombay lies to the north of the city and is distant about six miles. It is quite isolated and stands upon rising ground. The site was given by a Parsi, who in 1885 erected a large well-built bungalow for the use of lepers of all castes and creeds. It is a semi-religious charity, the inmates, twenty-four in number, being all Native Christians.

In the middle of the bazaar, closely surrounded by houses, is the Dharmasala founded by Sir Jamsctjee Jeejeebhoy. This is entered from Duncan Street. A colony of about one hundred and seventy lepers—men, women, and children, healthy and diseased—inhabit the place, which consists of several alleys along which water trickles in a central gutter, with badly built mud huts on both sides. The lepers are free to come or go, and by the provision of the founder each man and woman receives daily one seer of rice and three pie (about $\frac{1}{2}$ d.), and each child half a seer of rice and two pie.

The Superintendent of the Dharmasala has been resident there for twelve years and continued free from leprosy. His predecessor lived in the same quarters for thirty years and did not develop the disease. The indigent quarter of the Dharmasala is close to the leper colony, yet no instance could be discovered showing that the disease spread to the former.

The recently erected Asylum at Matoonga lies about six miles north of Bombay fort. The Institution was founded by subscriptions and municipal funds. On a site of several acres, enclosed with wire fencing, a number of blocks of buildings are raised. Each block is built upon slightly rising ground. The walls consist of a single course of bricks; the roof is constructed of palm leaves. The interior of each block is com-

pletely divided lengthways by a sheet of corrugated iron, eight feet high, so as to form two wards in each block. The floors are concrete and the walls whitewashed. Each ward contains about twenty beds. The whole is well ventilated. The sexes are separated. The sanitary arrangements are very good. The solid excreta are collected, removed, and subsequently thrown into the sea. The liquid matters run into gullies and thence into a main pipe which terminates in a percolating cesspool, made of morrum and ballast. A shaft, filled with chloride of lime, intercepts the drain, so that this disinfectant is slowly washed away into the interior of the pit.

POONA.

The David Sassoon Infirm Asylum is on the outskirts of the native city. It was founded in 1865 and contains seventy-seven inmates, among these thirty-five lepers (males twenty-three, females nine, children three). The lepers come from the neighbouring districts and are admitted at their own request. After admission they are not permitted to go out and beg, and if an inmate leaves without permission he is not re-admitted. The lepers live in detached bungalows, the sexes being separated. Separate buildings and latrines are arranged for the leprous and non-leprous inmates. Both the Superintendent of the Asylum, who has lived there for sixteen years, and the medical assistant, whose service has been seven years, are quite free from disease. No birth among the leper colony has occurred for many years. With the exception of the latrines the hygienic arrangements are good.

Forty-five cases were examined here, and among these there was only one Muhammadan. A single Brahmin was an inmate. Thirty-six patients were married, and the total number of children was forty-seven, giving 1·3 for each marriage.

Seventeen lepers had been vaccinated.

YERROWDA PRISON (POONA).

The Yerrowda Prison lies about four miles north of Poona. The leper criminals of the Presidency are collected here, and lodged in a separate building and do not mix with the healthy prisoners. One Brahmin was seen here and one Rajput belonging to the Bansi caste. According to the statement of this patient, members of this caste never, under any circumstances, eat fish, even in times of great scarcity. If fish were even at such times able to be procured, this would not be eaten. One prisoner has developed leprosy since admission to the Goal. To the ten married lepers twenty children had been born, or 2'0 children to each marriage.

Punjab.

DELHI.

There is no Asylum here, but twelve persons were collected for examination by the Civil Surgeon. Of these eleven were lepers, of whom six were Hindus, all of low castes (Chamar and weaver), and five Muhammadans. Nine were married and had thirty-three children in all, or 3'6 to each marriage. Ten were unvaccinated or inoculated. Where enquiries were made as to fish, all admitted they were frequent fish-eaters. It appears to be a common belief here that if fish is eaten and then milk drunk directly afterwards, that probably leprosy will be produced. It does not matter if fish be eaten on one day and milk on the next. It was also mentioned that at Garhmuktesar, twenty-five miles from Meerut, on the banks of the Ganges, there were a great number of lepers. One case of syphilis was produced as leprosy.

DHARMSALA.

A small colony of lepers inhabit two well-built huts, surrounded with gardens, situated on a hill some distance from the cantonment. Five men occupy one hut, and seven females the other; a compounder and his family occupy a third building on the same hill. He has been there thirteen years, and both himself and family are perfectly healthy.

LAHORE.

There is no Asylum at Lahore, neither is the district afflicted with leprosy to any marked extent. Two cases only were seen at the Civil Hospital, and both of these were vagrants who had come from Kashmir.

The prevalence of leprosy in the division and district of Lahore, according to the census of 1868 and that of 1881, is shown in the following table:—

		Population.	Total number of Lepers.	Proportion per 10,000 of population.
Lahore Division	1868	1,889,495	633	3'3
	1881	2,191,517	338	1'5
Lahore District	1868	789,666	106	1'3
	1881	924,106	84	'9

MOOLTAN.

Leprosy appears to be rare in this district. There was no case for examination, and during the past three-and-a-half

years not a single leper, either in the city or district, had been seen by the Civil Surgeon.

The following table shows the population and number of lepers in the district and division of Mooltan, according to the census of 1881:—

	Population.	Total number of Lepers.	Proportion per 10,000 of population.
Mooltan Division	1,712,394	215	1.2
Mooltan District	551,964	67	1.2

PESHAWAR.

This city and district is to a great extent free from leprosy, and although many cases were collected by the authorities, only two undoubted cases of leprosy were seen. The other patients were generally suffering from syphilis.

The accompanying table shows the population and number of lepers in the division and district of Peshawar, according to the census of 1881.

	Population.	Total number of Lepers.	Proportion per 10,000 of population.
Peshawar Division	1,181,289	269	2.2
Peshawar District	592,674	90	1.5

RAWALPINDI.

The Leper Asylum is situated about one mile east of the city. There was accommodation for about thirty-six lepers in 1883, but since that time, by the addition of new buildings, fifty lepers

can be admitted. Medical aid is rendered, and the establishment supervised by the Assistant Surgeon in charge of the Civil Hospital. The cost per annum of maintaining each leper is about Rs. 50.

Food consists chiefly of spiked millets during the winter months and wheat mixed with barley in the summer; meat, ghee, and vegetables according to their means.²

The Asylum contained forty-seven lepers and one patient free from the disease. Of this number forty-six were Muhammadans. A considerable number of lepers came from the Native State of Poonch on the eastern boundary of Kashmir. Thirty-two cases were married with fifty-two children, giving 1.6 to each marriage. Five cases had been vaccinated. Thirty-two cases had been inoculated.

SUBATHU.

This hill station lies about twenty-three miles south-west of Simla. There is a Leper Asylum here, supported by the American Mission to Lepers in India and by public contributions. It is under the superintendence of a resident missionary and a medical assistant. There is accommodation for eighty-five inmates. They occupy several buildings which are exceedingly comfortable. The patients are allowed to go outside the Asylum on certain days of the week. In addition to lepers other patients are received from charity. Medicine and advice are also given to lepers and patients suffering from other diseases. Forty-six lepers were examined here. Five patients stated that they had never eaten fish or meat. Forty-three were married and had forty-eight children.

SIALKOT.

The Leper Asylum at Baba Lakhon was founded in 1866. It is situated nine miles south of Sialkot. The buildings consist

(²) "Rawalpindi Gazetteer."

of three double barracks accommodating seventy-two lepers, a cookhouse, barrack for servants, two wells, and a garden. Medical attendance is given by the Assistant Surgeon of Sialkot. A few out-patients are also treated here. The average number of inmates from 1878 to 1891 was sixty-five. The cost per annum per inmate was about Rs 40.

The food of the people is chiefly grain and vegetables. Meat is a luxury few can afford. Fish is seldom eaten even by those residing near rivers.³

The Asylum has at present forty inmates, of whom thirty-two are Muhammadans and eight Hindus. Thirty-seven are married with fifty-seven children in all, giving 1.5 to each marriage. Ten cases had been vaccinated and two inoculated, while twenty-three had suffered from small-pox.

TARN TARAN (AMRITSAR).

The Leper Asylum at Tarn Taran is situated about one mile west of the town of that name. It was built in 1858. The buildings are two double rows of huts in lines of thirty-five each, and they will accommodate one hundred and forty inmates. Owing to the reputation that the water of a tank close to the temple founded by Arjan, the fifth Guru of the Sikhs, has for healing powers in leprosy, large numbers of lepers, who bathe in and drink the water, congregate in the town.

The Asylum is under the supervision of the Civil Surgeon of Amritsar, an Assistant Surgeon being in charge of the Institution. The Leper Asylum is maintained by the municipal funds of Amritsar, the expenses of lepers from other districts being recovered from the places to which they belong.

There are at present one hundred and forty-six inmates, one hundred and six of these being married. The total number of children is one hundred and eighty-five. Among twenty-

(³) "Sialkot Gazetteer."

two intermarriages of lepers it was found that eighteen children were born.

In 1889 the inmates numbered one hundred and eighteen, of whom seventy-five were males and forty-three females. Fifty of these were Muhammadans. An analysis of the total number⁴ showed that of one hundred and fourteen lepers—

Thirty-one admitted that fish was never eaten.

Five admitted that fish was seldom eaten.

Forty-two admitted that fish was often eaten.

Thirty-six admitted that a mixed diet was eaten.

Many wealthy lepers live in a separate quarter of the town of Tarn Taran. It was not possible to obtain any information from them.

UMBALLA.

The Asylum was founded in 1856. It is situated north-east of the city. The average number of in-patients is thirty-two, though there is accommodation for forty. There are no out-patients. It is under the superintendence of the American Missionary. Medicines are supplied *gratis* by the City Charitable Dispensary, and the Civil Surgeon visits the Asylum from time to time. The yearly expenditure is about Rs 1,700. Voluntary subscriptions for the most part defray the expenses. Clothing, food, medicines, and accommodation are given by this Asylum.

The staple food of the people is wheat and gram; dāl is also largely consumed.

Thirty-two lepers were examined.

Twenty-nine lepers were Hindus. With the exception of one Brahmin, most of these belonged to the Chamar, Dhobi, and other low castes.

Three were Muhammadans and Rajputs.

(⁴) Communication on January 8th, 1890, to Epid. Soc. of London by P. S. Abraham.

Twenty-nine lepers were married, and fifty-eight children were born in all, or 2.0 to each marriage.

Vaccination undergone by	.	.	.	.	.	7
Inoculation ditto do.	.	.	.	.	.	2
Small-pox ditto do.	.	.	.	.	.	7

Syphilis was not enquired into here.

Diet.—The Brahmins denied ever eating fish. This matter was fully gone into here, and out of the total thirty-two lepers it was found that—

- Fifteen owned to never eating fish, or 46.9 per cent.
- Twelve owned to sparingly eating fish, or 37.5 per cent.
- Five owned to frequently eating fish, or 15.6 per cent.

This Asylum contained one or two paupers, who were not lepers. One such case examined was hereditary syphilis.

Feudatory States.

KAPURTHALLA.

A small colony of ten lepers exists here, who live on the outskirts of the native city. All were Muhammadans. Of this number six were married, with a total of twelve children. Four cases had been vaccinated.

PATIALA.

Nine lepers were seen here, and several other patients collected with these were suffering from syphilis and other diseases. Six were Hindus, and among these two Brahmins; three were Muhammadans. To seven married lepers there were born seven children. No case had been vaccinated.

North-West Provinces and Oudh.

AGRA.

A leper colony is collected in a building close to the walls of the Taj Mahal. A set of buildings arranged as two quadrangles, the larger one for men and the smaller for women, so that the sexes are separated, are occupied by fifty-four lepers. Among twenty Hindus there were three Brahmins. Thirty-eight lepers were married. The number of children was sixty-seven. Seven cases had been vaccinated.

ALIGARH.

Cases were examined at the Civil Hospital. Among ten cases seven were Hindus and three Muhammadans; included in the former was one Brahmin. Among eight marriages there were in all thirty-five children, or 4.3 to each marriage.

ALMORA

The establishment of the Almora Leper Asylum is the work of Sir Henry Ramsay, who, in 1840, was appointed Resident Civil Officer in Kumaun. At his own expense he raised a building on the eastern slope of Almora which could accommodate about thirty inmates, and with the help of friends sustained the expense of the maintenance of these. In 1850 the Institution was handed over to the London Missionary Society, and subsequently the site changed to the present one on an isolated hill, south-east of the station. There are now seven barracks which will accommodate one hundred and thirty inmates, a bungalow for the resident care-taker, a dispensary, a store-room, a school and a church, together with out-houses for servants and attendants. All the buildings are of stone with slate roofs. Each barrack is divided into com-

partments, one of which will accommodate three inmates. A wall surrounds the compound which is well planted with cherry, plum, and other fruit trees within this area. Crops of potatoes, vegetables, and grain of all sorts are cultivated by the inmates, who themselves use the produce. The trenching system is adopted as a sanitary measure.

The number of inmates is generally greater in summer than in winter, for residence is quite voluntary. The sexes are strictly separated, and children born here removed into an Orphanage in Almora.

The income of the Institution is derived from a yearly grant made by the Mission to lepers in India of R2,400, and one of R120 from the Almora Municipality, aided by a few private subscriptions. There is also an endowment which yields yearly R2,145. During the year 1890 the expenditure was as follows:—

	R	a.
Diet, clothing, firewood	4,740	12
Repairs, medicine, funeral expenses	662	4
Establishment, including care-taker	647	0
	<u>6,050</u>	<u>0</u>

By the rules of the Institution attendance at the church and school is voluntary, and all are treated alike without reference to race or creed. Bathing once a week in the bath-rooms provided for the purpose is compulsory, and the clothing must be washed at the same time. Any inmate disregarding the rules is either excluded for a time from the rest of the community, or expelled from the Institution, according to the gravity of the offence.⁵

Leprosy is prevalent in the district of Kumaun. The figures available show that about twenty per ten thousand of the population are lepers, the ratio for the whole of India being five to ten thousand. Possibly this fact may be explained

(⁵) This information was kindly supplied by the Revd. G. M. Bulloch.

by assuming there is an immigration from Nepal, in which country it is said that lepers have been buried alive.⁶

There are at present one hundred and eight inmates, ninety-three are Hindus, sixteen Brahmins, and a single Muhammadan. A certain number of these come from Nepal and Garhwal. Very few are from the plains. Sixty-one lepers were married. Number of children one hundred and seventeen, that is, 1·9 to each marriage. Forty-two cases had been vaccinated, and forty-one inoculated.

BENARES.

Thirty-six lepers were examined here at the Secrole Dispensary. Four patients who had been collected were not lepers. Details as to religion, in twenty-eight cases, showed that twenty-six were Hindus and two Muhammadans, and among the former six Brahmins, all of whom state that they had never eaten fish. When enquiring about the Koeri caste (cultivators and gardeners), it appeared that there are two sub-divisions of this, the Sakatiha who eat fish and meat, and the Bhagatiha who never eat fish and meat.

Twenty-seven lepers were married; the total number of children was sixty-four, giving 2·3 children for each marriage.

The number vaccinated was four.

CAWNPORE.

In the opinion of the Civil Surgeon there were very few lepers in Cawnpore. Those that were seen appeared to be confirmed beggars. Ten lepers were examined here. Nine were Hindus, among these three Brahmins. One was a Muhammadan. All were married. Total number of children born fifteen, ten before and five after the disease appeared in the parent, or 1·5 to each marriage. None had been

(⁶) Report on Leprosy in India; Lewis and Cunningham, Calcutta, 1877.

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large for the suburbs. The Hindus suffered more from the disease than the Muhammadans. The following table gives the percentage of lepers on the total population of the city and suburbs:—

	City.	Suburbs.
Hindus	'009	'013
Muhammadans	'007	'007
Christians	...	...
TOTAL	'016	'022

There was in 1881 for the city one leper to every six thousand one hundred and eighty-three of the population, and for the suburbs one to every four thousand three hundred and sixty-three.

Mysore.

BANGALORE.

There is a small colony of lepers here which occupies a building attached to the Lunatic Asylum. At the commencement of 1890, there were twenty-five inmates, fourteen males and eleven females. By November of the same year, eleven additional cases, six men and five women, had been admitted. Twenty-three cases were examined in the Asylum and forty in a compound adjoining the Civil Hospital. Forty-three lepers were married. The total number of children born to these was seventy-two, or 1·6 to each marriage. Thirteen cases had been vaccinated.

The records of the Asylum show that in no single instance has any inmate of the Lunatic Asylum ever contracted leprosy. Elephantiasis was associated with leprosy in one case that was examined. An extensive trial of various modes of treatment

Local Notes:—Kashmir.

for the disease has been carried out by Brigade-Surgeon McGann in the Asylum. These include the employment of Hoangnan, Gurjun, and Chaulmoogra oil, and Unna's treatment with Ichthyol and Resorcin.

A census made in 1890 showed the total number of lepers in Mysore to be five hundred and seventy. The following table gives the number in various districts of this State:—

Bangalore	189	Shimoga	2
Kolar	105	Kadur	19
Tumkur	23	Chitaldroog	31
Mysore	192	Hassan	8

Kashmir.

JUMMOO.

This city and the surrounding area appeared almost free from leprosy. Only two cases were examined here; both were Hindus, married, with three children free from disease. One of the lepers had been vaccinated.

With reference to leprosy in Kashmir it has been noticed that the neighbouring Native State of Punch supplied many inmates for the Asylum at Rawalpindi. Quite recently a Leper Asylum has been established at Srinagar. A leper census, showing the prevalence of the disease in the valley of Kashmir for 1890, is given in the following table:—

	Men.	Women.	Muhamma- dans.	Hindus.
Srinagar	25	11	36	...
Anantnag	23	4	26	1
Kamraj	57	13	69	1
Muzaffarabad	62	6	66	2
TOTAL	167	34	197	4

CHAPTER III.

Geographical Distribution of Leprosy in India and its Relation to Climate, Soil, and Race.

IN an enquiry into the leper population of India many difficulties present themselves. The only source of information is found in the Imperial Census Reports. The census was instituted some twenty years ago, so that at present three sets of figures regarding the population are available. The lepers were enumerated on all three occasions. But since the diagnosis as to what constitutes a leper is as a rule left to unprofessional enumerators, the figures cannot possess an absolute value. There can be no doubt that in the censuses, especially in the first two, many cases of leukoderma have been included under the heading of leprosy and, on the other hand, many cases of leprosy must have been omitted in all three enumerations.¹ It is more than probable, that especially in the case of women, the returns are very faulty and imperfect. No doubt men suffer more than women, but it would be erroneous to argue exclusively from census returns, for the "purda" cuts off all possibility of verification.

Though these decennial figures cannot be said to have an absolute value, are they altogether worthless? By no means, for they possess a high relative value, which is greatly enhanced as census follows census. It may be assumed that the errors for each particular occasion are more or less evenly distributed over the country, so that one census by itself fully justifies comparative considerations. When, however, means exists to check one set of figures with an other, the value of such

(1) To obtain an estimate of the amount of errors that do occur, reference should be made to the appendix to this chapter "Census, 1871, Bombay." Here for a few districts two sets of figures are given, one for true and false leprosy without distinction, and another for the true disease only. The differences are remarkable.

Distribution of Leprosy.

considerations is greatly increased. When, for instance, it is found that the specific leper population for Sind was very small in 1872 and likewise in 1881 and 1891, and when the different conditions under which the census was taken on the three occasions are taken cognizance of, it must be regarded as established that here leprosy is not prevalent. Again, when a district or division periodically returns a high percentage of lepers, no reasonable doubt can exist as to the frequency of the disease over such area. Could enumerations take place at oft-repeated intervals, the figures would well nigh be of absolute value.

On the other hand, how does the case stand, when such questions as the increase or decrease of leprosy from year to year or from decade to decade, are raised? Here the difficulties are still greater and under the existing conditions the greatest care must be exercised. For from three sets of figures arguments can only be deduced with caution, especially if these figures have merely a more or less relative value. Therefore all that will be said regarding this point must be taken rather as suggestions which gain in value as the figures approach the standard of correctness. The Commissioners have felt all along the insecurity of the ground invaded, and this chapter shall point out how various are the factors which possibly may have an influence over the leper population, and that before the alarming statements of the rapid increase of leprosy over India are accepted, the most critical and scrupulous tests must be applied. Leprosy has been called an "Imperial Danger," which as such deserves the fullest attention of the Government of India. Imperial, no doubt, leprosy is, for no part of India is free from it, but a danger it can only be, if it be shown to increase at such a rate as to undermine the health and life of the general population. Those who speak of the great spread of the disease can evidently have no other support for their arguments than that afforded by census returns, and they must stand or fall by them: for them the value of these figures is absolute. This matter, therefore, as to how far leprosy is

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vaccinated. The three Brahmins denied that they had ever eaten fish. Little information was gained here. There were eight anæsthetic cases and two examples of the mixed form of the disease. No evidence of hereditary or collateral taints was elicited by examination.

DEHRA DUN.

The Asylum which Surgeon-Major G. G. Maclaren commenced to build in 1877, stands upon a site, about four acres in area, which lies south of the town of Dehra. The money for this was raised by voluntary subscriptions and donations put aside for the purpose since 1872. After the erection in 1878, Government gave an annual grant-in-aid of Rs 1,500, and the total income of the Institution in 1890 was Rs 5,280. The number of inmates that year was one hundred and one, so that there is a yearly cost per inmate of about Rs 52.

The whole compound is enclosed. About two-thirds of this space is occupied by a garden in which fruit trees (mango, guava, jack, plantain) and tea bushes are cultivated for the use of the inmates. The remaining space is divided into two by a high wall, on either side of which a long building, divided into compartments, each capable of accommodating eight to ten people, is constructed. The sloping roofs of these two buildings project forward about six feet, and form a verandah. The men's quarters are on one side, the women's on the other of this wall, so that there is complete separation of the sexes. The dry-earth and trench systems are adopted as sanitary measures.

By the rules of the Asylum admission is voluntary, but when a leper has availed himself of this benefit, his permanent residence here is insisted upon. There is no objection, should a leper from a distant district wish for admission. As a matter of fact a large number come from Garhwal. It is rare for a Muhammadan to become an inmate.

Local Notes:—North-West Provinces and Oudh.

There are eighty-eight inmates, sixty-nine Hindus, thirteen Brahmins, three Muhammadans, and one European. Seventy-one lepers are married, and the number of children one hundred and seventy-four, or 2.4 children to each marriage. Fifteen patients had been vaccinated.

FYZABAD AND AJODHYA.

In Fyzabad, together with Ajodhya, five miles distant, eighteen lepers were examined. Among this number was one Brahmin. Thirteen were married; number of children twenty, or 1.5 to each marriage. One case that was seen was not leprosy.

LUCKNOW.

There is no Asylum at Lucknow, but fourteen lepers occupy the poor-house, and are under the charge of the Civil Surgeon. Of these six were Muhammadans. Eleven were married. Number of children thirteen. Among the lepers there were two intermarriages, but no children had been born. One patient who had been admitted as a leper was suffering from epilepsy.

NAINI AND ALLAHABAD.

Sixty-six lepers collected from the prisons of the district were seen in the Gaol at Naini. One Brahmin and one Burman were among this number. Fifty-three patients were married, and the total number of children was seventy-four, giving 1.3 to each marriage.

Twelve lepers had been vaccinated.

NAINI TAL.

Leprosy is not very prevalent here. Only two cases were examined, both were Hindus. One was married and had a single child. One case had been vaccinated.

an "Imperial Danger," and as such of the greatest importance to the empire, will be fully considered.

When in the following pages allusion is often made to the uncertainty of the figures, this will bear testimony to the great doubt with which the Commissioners approached many questions and the hesitation with which they venture to suggest certain lines of arguments or personal opinions regarding a country of which they know but little and which to Western Europe at present is almost a *terra incognita*, so far as those points are concerned which may be said to be of ætiological importance in the causation of disease. Comparisons between Indian and European life are only too readily made, and in the study of a disease the Western standard applied to all conditions alike. The ignorance and want of education of the population, often called the "Indian People," not to speak of the vastness of the empire, are altogether lost sight of. Then again there is the Oriental indifference which is encountered everywhere and the eagerness of the Indians to agree with any suggestion made by the enquirer. "Especial care will always be requisite in collecting statistics of this kind to guard against the incurable proneness of ordinary natives to report as the result of any investigation whatever in their opinion their immediate superior wishes the result to be."² Those who most fully appreciate these differences between Western and Eastern conditions will best understand the great diffidence with which the Commissioners have ventured to express their personal opinions on many questions discussed in this chapter.

Geographical Distribution of Leprosy.

I.—The following remarks apply in the first instance to British India, as less accurate data are obtainable regarding the Native and Feudatory States, and as these are of less interest in a strictly imperial question, being outside the pale

of the Government. Three maps are appended showing not only the distribution but also the prevalence of the disease over the country. The maps have been compiled after the leprosy-map of Drs. Lewis and Cunningham,³ and all three may be regarded as fairly accurate representations of the relative amount of leprosy existing in the different parts of India. The Commissioners consider it their pleasant duty here to acknowledge the assistance they have obtained from Colonel Waterhouse, Assistant Surveyor-General of India.

A glance at the maps shows that leprosy is found in all parts of British India, and it is known that it also occurs in all Native States. The latter were enumerated in the recent census under the supervision of the Imperial Census Commissioner, and have been in part included in Map III. The prevalence of the disease, however, varies in the different presidencies and provinces. To clearly demonstrate this point various tints have been employed: red representing the lowest ratios, and brown, yellow, green, blue, and black the amount of leprosy according to the census figures or the various districts in an ascending order.

It will also be seen that the relative prevalence varies within certain limits for each of the three decennial periods. Thus, in 1872, "leprosy prevailed to an extraordinary extent in Beerbhoom and Bankoora in the Burdwan Division of Lower Bengal, in the Kumaun Division of the North-Western Provinces, extending across the southern range of the Himalayas; and in the Deccan and Konkan Divisions of the Bombay Presidency. The latter area, considered as a whole, does not show such an extreme prevalence as the two others: leprosy is, however, extremely prevalent, and in some districts, such as Barsi, Sowda, and Rajapur, abounds to a degree as great as is manifested in Beerbhoom, Bankoora, and Kumaun."⁴ "Of the three presidencies, Madras, though not containing

(²) Report on the Census of Oudh, Vol. I, page 151.

(³) Leprosy in India. A Report by T. R. Lewis, M.B., and D.D. Cunningham, M.P.

(⁴) Lewis and Cunningham. Op. cit., page 3.

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the fewest lepers, taking the absolute numbers, presents the lowest ratio, *viz.*, forty-four to a hundred thousand, whereas Bombay presents a proportion of leprosy population nearly double that of Madras, eighty-five lepers to every one hundred thousand, although the absolute number of lepers in the Bombay Presidency is slightly fewer.⁵ The presidency of Bengal furnishes an intermediate proportion; very considerably lower, however, when the whole presidency is considered than that of Bombay. One of the divisions in Bengal—Burdwan—contains a greater proportion of lepers, and absolute numbers almost as great as those of the whole of the Bombay or Madras Presidency."⁶

According to the census of 1881, of the three presidencies Madras again presents the lowest ratio, *viz.*, forty-seven to a hundred thousand, while Bombay, though containing the fewest lepers in absolute numbers, holds an intermediate position, showing a proportion of sixty-one to a hundred thousand; Bengal just exceeding this. As in 1871, the disease is found to be most prevalent in Bankoora and Beerbhoom; next in the Simla District, Dehra Dun, in Kumaun (especially in the Almora District): the number of lepers in every one hundred thousand varying from one hundred and sixty-one to three hundred and seventy-two. There is very little change with regard to the Deccan and Konkan Divisions of the Bombay Presidency as compared with 1871, but according to Mr. Baines's Census Report for 1881 "leprosy is probably returned in greater number than it should be, owing to the inclusion of cases of the false or discolorative disease."

Finally, the present census of 1891 shows a general decrease of leprosy all over India. The leprosy-map is also more complete, as Hyderabad, Rajputana, Upper Burma, and other areas have been included in the general enumeration. Unfortunately the Central Provinces, the greater portion of the Central India Agency and the Feudatory States had to be omitted, as at the

(⁵) In the Bombay Presidency, however, no distinction was drawn between "white" and "black or true" leprosy, so that the figures for the area are too high.

(⁶) Lewis and Cunningham. *Op. cit.*, pages 3 and 4.

Distribution of Leprosy.

time of writing the necessary returns were unobtainable. All the statistical figures relating to these tracts had to be dispensed with. This fact will not affect the arguments as to the possible increase or decrease of leprosy in the slightest, but the Commissioners greatly regret that through waiting several months for such returns much valuable time has been lost and the appearance of this Report unnecessarily delayed.

In the British territory the highest ratios once more are found in Bankoora and Beerbhoom, the number of lepers in every one hundred thousand amounting to about three hundred and fifty. Burdwan, Simla, Dehra Dun, and Kumaun again show a comparatively great prevalence of the disease. Altogether the remarks on the previous censuses apply to the present one—a distinct confirmation of the relative accuracy of the figures and ratios—and it is therefore not necessary to discuss the matter further, especially as the maps will give a better and more complete idea of the changes that have taken place in the leper population than any description or comments in words.

Two tables will now be given to show the number and proportion of lepers in the three presidencies, and the most affected districts according to the three censuses.

TABLE I.

To show the Changes in the Number and Proportion of Lepers in the three Presidencies according to the three Census Returns (British Territory only).

PRESIDENCY.	Total population (1st census).	Total number of lepers.	Proportion per 10,000.	Total population (2nd census).	Total number of lepers.	Proportion per 10,000.	Total population (3rd census).	Total number of lepers.	Proportion per 10,000.	REMARKS.
Bengal	134,245,128	70,698	5.2	146,752,868	92,181	6.2	147,399,804	76,079	5.1	For 1891 Andaman Isles and a few railways and cantonments have been omitted, and also the Central Provinces. These omissions naturally do not considerably affect the leper ratios. The returns for Bengal are incomplete (cf. Appendix to this Chapter).
Madras	30,835,577	13,347	4.4	29,916,629	14,088	4.7	34,336,192	11,967	3.4	
Bombay	16,228,774	13,242	8.5	16,489,274	19,095	11.6	18,907,123	10,187	5.3	
Lower Burma	2,747,148	3,203	11.6	3,736,771	2,589	6.9	4,658,627	2,960	6.3	
Upper Burma	...	...	...	...	...	...	2,646,550	3,504	13.2	
GRAND TOTAL IN BRITISH INDIA	184,055,627	101,590	5.5	196,395,542	118,953	6.0	208,242,300	104,697	5.0	

Table III—continued.

Relation of Syphilis to Leprosy.

ASYLUM OR LOCALITY.	SYPHILIS CASES.			REMARKS.
	Before Leprosy.	After Leprosy.	TOTAL.	
Bangalore . . .	1	1	2	
Belgaum . . .	2	...	2	
Benares . . .	3	...	3	
Burdwan . . .	5	...	5	
Calcutta . . .	10 ²	2	12	(²) One case contracted syphilis at the same time he became a leper.
Calicut . . .	1	...	1	
Dehra Dun . . .	5	2	7	
Delhi . . .	1	...	1	
Dharmasala . . .	4	...	4	
Fyzabad . . .	3	...	3	
Gya . . .	11	...	11	
Jubbulpore . . .	2	...	2	
Kapurthalla . . .	1	...	1	
Lucknow . . .	2	...	2	
Madras . . .	2	...	2	
Mandalay . . .	21	1	22	
Moulmein . . .	4 ⁸	...	4	(²) One case contracted syphilis about the time he became a leper.
Nagpur . . .	22	2	24	
Naini and Allahabad	1	...	1	
Naini Tal . . .	1	...	1	
Peshawar . . .	2	...	2	
Prome . . .	6 ⁴	...	6	(⁴) One case contracted syphilis about the time leprosy began.
Purulia . . .	4	...	4	
Rawalpindi . . .	1	...	1	
Sialkot . . .	1	...	1	
Tanjore . . .	1	...	1	

Table III—continued.

Relation of Syphilis to Leprosy.

ASYLUM OR LOCALITY.	SYPHILIS CASES.			REMARKS.
	Before Leprosy.	After Leprosy.	TOTAL.	
Tarn Taran . . .	2	...	2	
Thayctinyo . . .	6 ⁵	3	9	(⁵) One case contracted syphilis about the time he became a leper.
Trichinopoly . . .	1	...	1	
Umballa . . .	2	...	2	
TOTAL . . .	142	12	154	

Again, even allowing that a certain number of the 154 cases specified in Table III were instances of gonorrhœa, does not the fact that the remainder contracted syphilis at all—and many of them had undoubtedly done so—militate against Sir W. J. Moore's theory? For as these men became lepers they must have been born in the particular phase of congenital syphilis. How, then, is it to be explained that many of these men presented the typical signs of tertiary syphilis concurrently with those of leprosy?

Lastly, it has never been shown that syphilis passes into leprosy, or *vice versa*. Nor does syphilis ever modify the progress of the local changes in leprosy; and the converse also holds good.²⁷ In conclusion, all that has been said on heredity may be used as arguments against this hypothesis.

It is, therefore, impossible to regard syphilis as having any real or specific influence on the production of the disease, or as acting otherwise than by lowering the general tone of the system, and thereby rendering it more liable to attack by, or hastening the progress of, leprosy.

(²⁷) R. Virchow: *op. cit.*, page 501.

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Table II—continued.

To show the Changes in the Number of Lepers of the Districts which contain the largest Porportion of Lepers according to the three Censuses.

PRESI- DENCY.	DISTRICT.	PROPORTION OF LEPEES PER 10,000 IN			REMARKS.
		1st Census.	2nd Census.	3rd Census.	
MADRAS AND BURMA.	Amherst .	14.7	4.5	2.5	
	Bassein .	12.3	10.8	8.4	
	Chingleput .	6.1	10.0	6.0	
	Madras City .	10.5	10.7	7.6	
	Northern Ara- kan .	28.4	16.5	28.0	
	Rangoon Town .	10.5	6.0	3.7	
	Shwegyin .	17.6	7.9	4.8	
	Thayetmyo .	10.2	6.4	6.5	
	Toungoo .	31.5	7.9	5.9	
BOMBAY	Ahmednagar .	14.0	10.1	7.8	
	Belgaum .	10.0 (5.1)	3.3	3.3	Only in Belgaum, Panch Mahals, Kutch, and Hyderabad distinction was drawn in 1872 between "white" and "black" leprosy, so that the ratios given in the first column are too high. The figure in brackets signifies the ratio of true lepers for Belgaum. In 1881 again it appears probable that in Khandesh and one or two other districts of the Deccan and Konkan Divisions cases of white leprosy have been in- cluded with the true disease.
	Dharwar .	11.6	1.8	2.0	
	Khandesh .	14.8	14.1	11.6	
	Kolaba .	12.6	11.3	9.1	
	Poona .	12.0	12.0	10.0	
	Ratnagiri .	12.1	9.3	9.7	
	Satara .	11.8	11.0	12.1	
	Sholapur .	11.9	6.8	8.0	

In Table II some of those districts are given in which leprosy is most prevalent, and such tracts of the country have been selected which in any one census showed a proportion of at least one in thousand. By also noting the proportions for

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the other two censuses facilities are given to study any changes in the relative leper proportion that may have occurred.

It will be found that, generally speaking, the ratios for the present census are lowest, thus indicating a relative, if not an absolute, decrease of leprosy, as far as it is possible to argue from such figures.

"The foregoing numerical data regarding the distribution of leprosy in British India can, as already stated, be accepted as only approximately correct, so far as the actual enumeration of the lepers is concerned, but what is probably of considerably more importance in connexion with the study of its ætiology is, that they convey fairly accurate information regarding the particular parts of the country where the disease is most prevalent."

II.—It has been maintained that leprosy is most prevalent on the sea coast or the borders of large rivers.⁸ With regard to India, Mr. Hutchinson asserts⁹ that the chief prevalence of the disease is on the seaboard or in the valleys. Leprosy, as was mentioned above, is found all over India, and it remains to examine whether it is more common along the sea coast and large rivers. Looking at the map for 1872 it becomes evident that the districts where the disease is most prevalent are as a rule inland.

Taking the evidence afforded by the two previous censuses first, amongst the facts conveyed by the maps this is brought out most strikingly, that all along the Gangetic Valley, fifty to one hundred miles north and south of the Ganges, the ratio of lepers is lowest, with the exception of the Burdwan Division. At the delta itself the proportion may be said to be about five to ten thousand. The same applies to the area included between

(7) Lewis and Cunningham. Op. cit., page 8.

(8) Journal of the Leprosy Investigation Committee, No. I, August 1890, page 78; Virchow, Krankhafte Geschwülste, page 507.

(9) Journal of the Leprosy Investigation Committee, No. I, August 1890, page 82.

TABLE I-a

To show the Changes in the Number and Proportion of Lepers in the three Presidencies according to the three Census Returns (inclusive of Feudatory States).

Presidency.	Total population (1st census).	Total number of lepers.	Proportion per 10,000.	Total population (2nd census).	Total number of lepers.	Proportion per 10,000.	Total population (3rd census).	Total number of lepers.	Proportion per 10,000.	REMARKS.
Bengal . . .	135,394,838	71,287	5.2	154,106,069	98,017	6.3	155,818,269	80,426	5.1	In this table besides the returns for the areas mentioned in the previous reports (Table I), also those for the Central India Agency, Hyderabad and Rajputana have been omitted. For a complete comparison the appendix to this chapter should be consulted. The returns for Bengal (cf. Appendix to this chapter).
Madras . . .	31,152,272	13,944	4.4	31,170,631	14,525	4.6	38,471,281	13,771	3.7	
Bombay . . .	23,863,187	18,794	7.8	23,301,370	12,382	5.3	26,960,421	12,741	4.7	
Lower Burma . . .	2,747,148	3,203	11.6	3,736,771	2,589	6.9	4,658,627	2,960	6.3	
Upper Burma . . .	...	...	...	...	...	...	2,946,550	5,504	11.8	
Mysore and Coorg . . .	5,223,724	1,579	3.0	4,364,490	576	1.3	5,116,659	837	1.6	
GRAND TOTAL FOR INDIA . . .	198,281,169	108,807	5.4	216,679,331	128,089	5.9	233,971,807	114,239	4.8	

TABLE II.

To show the Changes in the Number of Lepers of the Districts which contain the largest Proportion of Lepers according to the three Censuses.

PRESIDENCY.	DISTRICT.	PROPORTION OF LEPEBS PER 10,000 IN			REMARKS.
		1st Census.	2nd Census.	3rd Census.	
BENGAL	Akola . . .	5.3	17.0	15.8	All Feudatory States have been omitted, and also those districts which were not enumerated on all three occasions.
	Amraoti . . .	6.8	16.2	14.2	
	Balasore . . .	2.5	13.7	12.0	
	Banda . . .	13.1	12.2	6.3	
	Bankoora . . .	29.9	37.2	36.3	
	Beerbhoom . . .	41.2	32.7	35.2	
	Burdwan . . .	22.6	29.5	21.5	
	Cachar . . .	4.7	7.8	11.6	
	Cuttack . . .	2.9	11.2	8.6	
	Darjeeling . . .	10.0	11.8	7.5	
	Dehra Dun . . .	19.0	19.9	20.5	
	Ellichpur . . .	5.6	13.4	16.5	
	Garhwal . . .	24.0	18.1	16.9	
	Goalpara . . .	7.3	11.5	19.3	
	Jalpaiguri . . .	4.5	12.9	9.9	
	Kangra . . .	18.0	14.5	10.8	
	Manbhoom . . .	5.4	12.3	12.3	
	Moradabad . . .	5.7	11.6	5.8	
	Moorshedabad . . .	13.1	12.7	8.2	
	Nagpur . . .	3.9	12.1	*	
	Pooree . . .	3.3	13.6	15.5	* Returns not received.
	Rawalpindi . . .	10.4	5.0	3.6	
	Rungpore . . .	10.7	14.9	6.8	
	Simla . . .	34.7	28.6	28.8	
	Sylhet . . .	10.0	7.3	13.5	† Returns not received.
	Wardha . . .	6.8	12.9	†	

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Hence, with regard to the geographical distribution of leprosy in India, it cannot be said that the sea coast, riparian areas or large valleys are affected more than other districts in the country. The disease attacks all tracts impartially, and so far as the surface relations are concerned no generalisations whatever can be made. Similarly no connexion can be traced between the geological formations and the density or distribution of the leper population.

These lines may suffice as mere outlines of the geographical distribution of leprosy in India, which may be studied more completely by careful reference to the maps and the appendix than by a lengthy exposition and cumbersome statistics.

Increase of Leprosy.

In Table I the Feudatory States have been omitted, for the reason stated above. For completeness' sake a table was added to show the ratios of lepers for British as well as Feudatory territory (Table I-a.)

In comparing the figures of the three censuses with a view to studying the changes in the leper population from one decade to another, it must be remembered that the later censuses included districts and areas which were omitted in the earlier; again, that the first census was not taken on the same day or at the same time all over India; and that also as time progresses the diagnostic powers of the people have improved. To investigate the movement in the leper population, Table I-b has been constructed, including under each census only those districts which were enumerated on all three occasions. But even then it must not be left out of sight that changes in the divisions themselves have taken place from time to time, one district having been given over from one division to another. Selecting, however, as carefully as possible those districts for which returns were made at all three censuses, the Table I-b permits of a comparison being made

Distribution of Leprosy.

of the three sets of figures available. Even making all due allowances for errors, omissions, and changes in areas, it is plain that the recent outcry about an alarming increase of leprosy in British India is not based on fact, and that such increase has not taken place. On the other hand, the figures suggest a decrease rather than an increase, especially if it be remembered that immigration of lepers into British territory takes place to a great extent.

TABLE I-b.

Increase of Leprosy in British India.

Total population at each census on which the leper-ratios have been calculated.	Number of Lepers.	Ratio per 10,000.	REMARKS.
1st Census (1867-72). 182,000,000	100,000	5.0	Only those districts and areas have been selected which were enumerated in all censuses. To facilitate calculation round numbers have been used, and the ratios are approximate only. It has been assumed that the number of lepers in the Central Provinces has remained stationary.
2nd Census (1881). 191,000,000	115,000	6.0	
3rd Census (1891). 210,000,000	105,000	5.0	

In arguing from this table great care must be employed. Comparing the first two censuses, there is an increase in the absolute number of lepers of fifteen thousand. The present enumeration, on the other hand, shows a great decrease, both absolute and relative, since the previous census, so that the recent alarm is quite unnecessary. While comparing the first two censuses, it must be remembered that on both occasions the diagnosis was greatly at fault, and that the presidencies on the first occasion were enumerated at different times. But even allowing the figures to be genuine, the increase is so small that it may easily be explained on the ground of faulty counting. For one mistake in ten thousand, or if the actual figures be taken, one mistake in twenty thousand would more than account for the increase of fifteen thousand. After all this increase, when compared with the total

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the five rivers of the Punjab. In fact, for the first and second censuses the smallest proportions of lepers were found in the four "doabs" between the Indus, the Jhelum, Chenab, Ravi, and Sutlej—and thence down the whole course of the Indus and along the coast from Kurrachee to Ahmedabad. So it is, generally speaking, with the other rivers. Thus along the banks of the Nerbadla the ratio was extremely low for 1871-72 and not excessive for 1881, while for the Koleroon river it was under five per ten thousand for both censuses, with the exception of Tanjore. Along the south banks of the Kistna and Tungabadra the distribution of lepers amounted in the first census to 3·5 per ten thousand and to less for 1881. On the other hand, along the Tapti a high ratio is found. *Now since also along the seaboard and larger rivers the prevalence of leprosy on an average is much below that of the inland areas, it cannot be said that the earlier enumerations establish any proof in favour of the statement that in India the disease has a preference for the former tracts.*

These were, however, the only figures at the disposal of writers previous to the recent census.

The records of the latter argue equally, if not more strongly, against the prevalence of leprosy along the shores of the sea or the banks of the large rivers. In the "doabs" the ratios are again low, and the same applies to the north-west coast and the seaboard in general. The map, however, gives a more graphic demonstration than words possibly can do, and reference should be made to the same.

III.—The maps convey the further information that some hill tracts are especially attacked by leprosy. This fact cannot be explained by immigration from adjoining native territories,—though this is responsible to a great degree for the high ratios in some districts,—but is apparently due to certain inherent conditions. The influence of immigration will be discussed later on. In all the three census reports some Himalayan districts show consistently a dense leper popula-

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tion, varying from one to four per thousand. Some of these will, for clearness' sake, also be given in a tabular form.

TABLE III.

Hill Districts of India with a dense Leper Population.

DISTRICT.	Proportion of lepers per 10,000 of population (1st Census).	Proportion of lepers per 10,000 of population (2nd Census).	Proportion of lepers per 10,000 of population (3rd Census).	REMARKS.
Bashahr . . .	...	16·9	13·3	
Chamba . . .	...	45·6	34·0	
Darjeeling . . .	10·0	11·8	7·5	
Dehra Dun . . .	19·0	19·9	20·5	
Garhwal (British) . . .	24·0	18·1	16·9	
Garhwal (Native) . . .	...	15·3	12·8	
Kangra . . .	18·0	14·5	10·8	
Kumaun . . .	19·0	21·0	19·7	
Mandi . . .	...	15·7	14·9	
Nahan . . .	...	47·9	21·2	
Simla, etc. . .	34·7	20 to 40	28·8	
Suket . . .	...	16·5	4·1	

Now in many of these hill tracts the people by no means confine themselves to the valleys. It is true that in the Himalayan districts of the Punjab the inhabitants do so more or less, but it must be remembered that many of their most densely populated places are at an height of from seven to eight thousand feet, and villages may be even found at a height of ten thousand feet.¹⁰

On the other hand, it must not be thought that leprosy is most frequent in the hills, for in the plains parts are found with an exceedingly high ratio of leper population, as a glance at the maps for 1881 and 1891 will show.

⁽¹⁰⁾ H. E. Blandford, India, Burma, and Ceylon, page 61.

population, is but slight and too small to stamp leprosy as an "Imperial Danger." For an increase of fifteen thousand means that of the population, after an interval varying from nine to fourteen years, less than 10001 became diseased. Such an increase, if it actually existed, can hardly be considered in the light of a danger. According to Table I the ratios of lepers per ten thousand of the population for the two periods were 5.5 and 6.0 respectively, a sufficiently strong argument against a rapid growth of leprosy. But the outcry about an alarming development of the pest becomes unreasonable, when the previous censuses are compared with the recent one, which shows an actual decrease.

It has been said above, that on the recent occasion greater care has been bestowed on the correctness of diagnosis and though cases undoubtedly have been omitted by the enumerators, fewer spurious ones have been admitted. This only shows how difficult it is to come to a correct opinion by means of a comparison of a few figures. But those who have raised the alarm have had no other means of verifying their premises than these census returns. It may be safer to suspend all judgment, but if a verdict is given on so grave a matter, it should be capable of the only proof existing at the present time, *viz.*, that afforded by the census figures. In the opinion of this Commission, a comparison of the first two censuses hardly points to an increase of leprosy, especially when it is considered that the first enumeration on account of its novelty was most likely more faulty, and not even taken at the same time all over India, and that an increase of .5 per ten thousand may be explained by the improved methods of enumeration. The errors of diagnosis were more or less equal for the two censuses. Again, while during the period from 1867 to 1881 the leper population remained probably more or less stationary, in the last decade there has been a decided decrease, according to the figures available. But it would be equally unsafe to assume that this represents an actual diminution of leprosy, for, as

was said above, great pains were taken in 1891 to exclude all cases of white leprosy. *Loath to give a decided opinion on this subject, the Commission think, that the evidence of the censuses excludes the idea of an increase of leprosy, and points rather to a gradual decrease at the present time; but it may be safer to assume that the diffusion of this disease has remained stationary.* Anyhow an "Imperial Danger" leprosy has not become as yet, for the previous increase is more than counterbalanced by the present decrease, as far as census figures go.

A comparative statement of the leper population arranged according to divisions follows (Table IV), and a map is appended to show the changes in the ratios since the second census (Map IV). Pink represents an increase, and light blue a decrease, in the leper density since 1881, the darker shades indicating that such increase or decrease has taken place since the first enumeration. The map has been compiled according to the ratios of the last two censuses, and should be compared with a similar one in Chapter VI showing the increase and decrease from the first to the second census on more general lines. It will be seen from Map IV that, broadly speaking, there has been a steady decrease of leprosy, as estimated by the census returns, in Bombay and Madras Presidencies, in the Punjab, North-Western Provinces, Lower Burma and Coorg, dark blue predominating over these areas. Since the last enumeration a general decrease is noticed in Bengal, while in Mysore and a few other tracts a slight increase has taken place. There are but few districts (dark red) in which the leper population has steadily increased during the last thirty years. The increase from 1881 to 1891 nowhere is great, and the ratios for 1891 are as a rule lower than those for 1867 and 1871. In studying the map it should be remembered that many districts were not enumerated on the first occasion, and careful reference should be made to the Appendix to this chapter. This, however, is evident from the

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Table IV—concluded.

Comparative Statement showing the Changes in the Leper Ratios since the first Census.

PROVINCE OR PRESIDENCY.	DIVISION.	Ratios per 10,000 (1st Census).	Ratios per 10,000 (2nd Census).	Ratios per 10,000 (3rd Census).	REMARKS.
Madras	Tanjore . . .	7.2	5.0	3.1	
	Trichinopoly . . .	2.8	4.0	2.3	
	Madura . . .	2.9	3.7	2.1	
	Tinnevely . . .	4.7	4.7	2.1	
	Salem . . .	2.8	2.2	1.2	
	Coimbatore . . .	2.2	1.4	.5	
	Nilgiris . . .	8.2	6.3	4.0	
	Malabar . . .	6.0	5.1	4.4	
	South Canara . . .	8.1	9.4	8.6	
	Madras City . . .	10.5	10.7	7.6	
	TOTAL FOR MADRAS PRESIDENCY . . .	4.4	4.7	3.4	
Lower Burma.	Arakan . . .	3.8	2.8	3.0	
	Pegu . . .	12.4	7.3	7.1	
	Irrawaddy . . .	...	9.5	8.7	
	Tenasserim . . .	15.7	5.5	3.7	
	TOTAL FOR LOWER BURMA . . .	11.6	6.9	6.3	
Bombay	Gujarat . . .	5.4	2.8	1.9	
	Konkan . . .	8.4	9.2	8.3	
	Deccan . . .	11.6	10.8	9.6	
	Western Karmatic . . .	...	2.4	2.7	
	Sind . . .	1.4	1.1	.7	
	City and Island of Bombay . . .	...	5.5	4.4	
	TOTAL FOR BOMBAY PRESIDENCY . . .	8.5	6.1	5.3	

Distribution of Leprosy.

Climate and Leprosy.

The climate, or more correctly speaking the climates, of India vary considerably in passing from east to west, or in comparing the extreme north with the most southerly provinces. Meaning by the term "climate" the average of the weather as hot or cold, dry or moist, at different seasons of the year, a brief enquiry will be made as to its possible influence on the distribution of leprosy. Climate cannot be considered the cause of the disease, for leprosy exists in all latitudes. By comparing the various districts of India, however, the atmospheric influences upon the malady may be more efficiently studied. It must not be forgotten that while discussing the relation between climate and leprosy in so vast a country, it is impossible to exclude all such factors as food, race, soil, and habits of the people.

Leprosy is undoubtedly more common between the tropics than in the temperate zones. India, lying half within the tropics, is nowhere free from this disease. Still the distribution of leprosy is very unequal, and it may be asked whether any law can be established between the dryness and heat of the climate and the number of the leper population.

To take dryness first. "The west coast of the Peninsula is very damp, whereas most of the Madras districts on the east coast, and still more those in the interior, have a comparatively dry climate. But the driest part of the Peninsula is the tableland around Bellary, the northern district of Mysore, and that part of the Bombay Presidency that lies between the Western ghâts and the Hyderabad State. In Northern India the contrast of dryness and dampness is even greater than in the Peninsula. Sind, with the South-Western Punjab and Western Rajputana, is exceedingly dry, so much so that large tracts are desert and devoid of vegetation, and agriculture is very

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map, that as far as census figures go, the relative decrease of leprosy since 1867 has been considerable.

It must again be insisted upon that the Commissioners do by no means regard such figures as absolutely correct, but nevertheless as the best obtainable and of some value. To reject them altogether and to substitute numbers derived from general impressions of medical officers whose attention has been suddenly attracted to the disease, and from the study of dispensary returns is unreasonable. Again by others the figures are objected to and considered worthless, since in an enumeration the diagnosis is left in the hands of civil and police authorities. No doubt this detracts greatly from their value, but as may be seen from the general remarks at the commencement of this report, the fault consists generally in the inclusion of errors. The Commissioners found, that where cases had been collected for their inspection by non-medical men as a rule, about 10 per cent. had to be rejected on account of a mistaken diagnosis. It may thus be claimed, with a fair amount of justness that whatever errors the census returns contain, they do not under-estimate the true state of affairs by much, if at all. But in any case, as has been said at the beginning of this section, those who have spoken of an alarming increase could not support their assertion except by the figures of the first and second censuses. The highest estimates of the actual leper population at the present time have been two hundred and fifty thousand and five hundred thousand ⁽¹⁾ and this, if true, would point to an enormous increase since 1881. But such calculations are based on impressions only and are mere guesses of extremely questionable, if any, value.

The lepers in India have been enumerated on three different occasions, each time by different men and under altered conditions, and yet we find that the figures of the three censuses agree as much as can be expected. The total of the leper population

⁽¹⁾ Journal of the Leprosy Investigation Committee, No. 11, page 56.

Distribution of Leprosy.

was somewhere about a hundred thousand in 1871 and this the original estimate has already been confirmed at two separate periods. This fact must clearly enhance whatever absolute value the figures may possess, and allowing that such differences as there are from census to census cannot be considered sufficiently conclusive to establish an actual increase or decrease, the only conclusion that can be supported by anything like logical evidence is that from a hundred thousand to one hundred and twenty thousand more or less accurately represents the leper population, and also that though it may be safer to assume that the latter has remained stationary, there is at least a marked tendency towards a gradual relative decrease.

TABLE IV.

Comparative Statement showing the Changes in the Leper Ratios since the first Census.

PROVINCE OR PRESIDENCY.	DIVISION.	Ratios per 10,000 (1st Census).	Ratios per 10,000 (2nd Census).	Ratios per 10,000 (3rd Census).	REMARKS.
Bengal.	Burdwan	16.5	19.5	16.6	
	Presidency	5.6	6.8	4.6	
	Rajshahye	6.9	9.2	5.3	
	Cooch Behar	5.7	...	...	
	Dacca	5.5	5.6	4.6	
	Chittagong	2.6	4.2	2.8	
	TOTAL FOR BENGAL PROPER	7.8	9.4	6.9	
	Patna	4.3	5.5	4.0	
	Bhagalpur	3.0	6.2	5.4	
	TOTAL FOR BEHAR	3.9	5.7	4.5	
	Orissa	2.4	12.4	11.0	
	Chota Nagpore	2.5	5.3	4.4	
	TOTAL FOR BENGAL	6.0	8.2	6.2	

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Table IV—continued.

Comparative Statement showing the Changes in the Leper Ratio since the first Census.

PROVINCE OR PRESIDENCY.	DIVISION.	Ratio per 10,000 (1st Census).	Ratio per 10,000 (2nd Census).	Ratio per 10,000 (3rd Census).	REMARKS.
Assam	Assam . . .	6.8*	7.0	12.3	* cf. Remarks in Table V.
	TOTAL FOR BENGAL INCLUDING ASSAM	5.9	8.0	6.6	
North-Western Provinces and Oudh.	Meerut . . .	2.9	3.2	2.4	
	Agra . . .	2.2	1.7	1.6	
	Rohilkhund . . .	4.2	5.8	3.9	
	Allahabad . . .	3.3	3.8	3.3	
	Benares . . .	1.9	3.6	2.8	
	Jhansi . . .	2.2	4.1	4.0	
	Kumaun . . .	21.1	16.1	15.5	
	TOTAL FOR THE NORTH-WESTERN PROVINCES . . .	3.2	4.0	3.4	
	Lucknow . . .	6.8	5.4	5.3	
	Sitapur . . .	7.1	3.9	3.6	
	Fyzabad . . .	6.9	3.1	3.8	
	Rae Bareli . . .	6.9	3.2	4.0	
Punjab	TOTAL FOR OUDH . . .	6.9	3.9	4.1	
	TOTAL FOR THE NORTH-WESTERN PROVINCES AND OUDH . . .	4.2	4.0	3.6	
	Delhi . . .	6.6	3.4	1.7	
	Hissar . . .	4.9	2.5	1.4	
	Umballa . . .	9.2	4.7	3.4	
	Jullundur . . .	11.1	7.6	5.1	
	Amritsar . . .	6.4	3.9	1.5	
	Lahore . . .	3.3	1.5	.8	
	Rawal Pindi . . .	7.3	4.5	2.5	

Distribution of Leprosy.

Table IV—continued.

Comparative Statement showing the Changes in the Leper Ratios since the first Census.

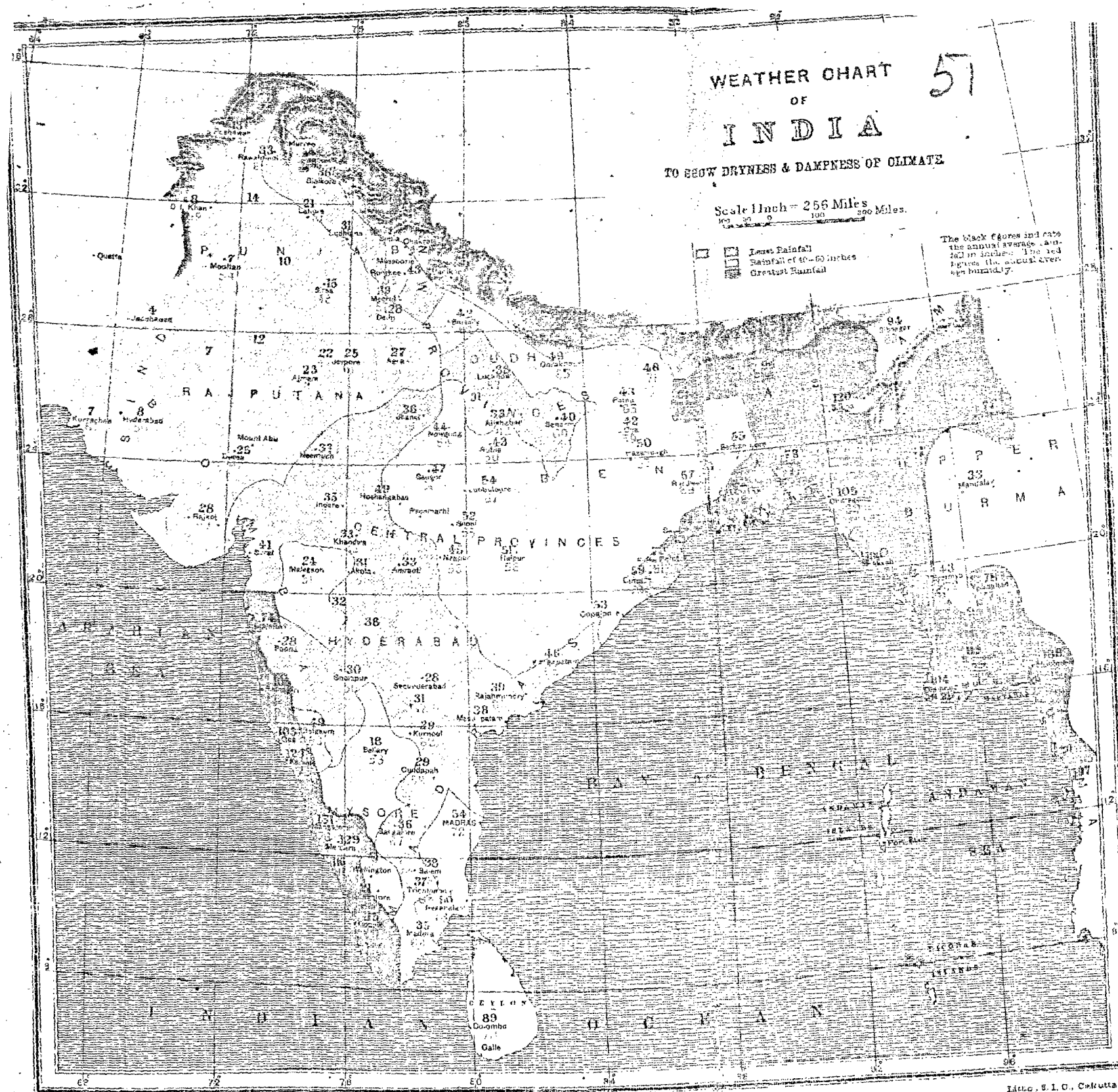
PROVINCE OR PRESIDENCY.	DIVISION.	Ratio per 10,000 (1st Census).	Ratio per 10,000 (2nd Census).	Ratio per 10,000 (3rd Census).	REMARKS.
Punjab	Mooltan . . .	3.0	1.2	.6	
	Derajat . . .	1.5	1.3	.6	
	Peshawar . . .	1.9	2.2	1.6	
	TOTAL FOR THE PUNJAB . . .	6.2	3.6	2.0	
Central Provinces.	Nagpur . . .	3.9	9.0		* Not received.
	Jubbulpore . . .	.7	2.8		
	Narbada . . .	3.4	5.2		
	Chhattisgarh . . .	2.6	7.7		
	Upper Godavari . . .	1.9	...		
Berar	TOTAL FOR THE CENTRAL PROVINCES . . .	2.7	6.5	†	† Not received.
	Berar . . .	6.4	14.0	12.7	
	Grand Total for Bengal Presidency . . .	5.2	6.2	5.1	
Madras	Ganjam . . .	5.0	4.0	5.1	
	Vizagapatam . . .	3.1	4.7	4.9	
	Godavari . . .	4.1	5.8	4.6	
	Kistna . . .	3.5	4.0	2.6	
	Nellore . . .	3.9	3.2	2.8	
	Cuddapah . . .	2.9	1.8	1.4	
	Kurnool . . .	3.6	3.4	2.0	
	Bellary . . .	3.7	2.6	2.8	
	Chingleput . . .	6.1	10.0	6.0	
	North Arcot . . .	6.2	6.3	5.2	
	South Arcot . . .	4.8	6.6	4.7	

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TABLE VI.
Leprosy and Heat.

[Census 1881 and 1891.]

Area.	Amount of Heat.	Ratio of Lepers per 10,000 (1881).	Ratio of Lepers per 10,000 (1891).	REMARK
Orissa	Very hot, 80° and above.	12.4	11.0	
Malabar		6.3	5.6	
Madras (South-Central)		2.8	.8	
East Coast		5.0	4.0	
Madras (South and Central)		2.8	.8	
Tenasserim	Hot, 78° and 79°.	4.2	2.6	
Burma		6.9	6.3	
East Bengal		5.5	4.3	
Deltaic Bengal		7.1	4.8	
Central Bengal		19.0	16.1	
Behar		5.7	5.0	
North-Western Provinces and Oudh		4.0	3.6	
Berari		14.0	12.7	
Kathiawar		2.2	1.5	
Sind		1.1	.7	
Cochin	Medium, 76° and 77°.	7.8	11.6	
Punjab (South and Central)		2.5	1.5	
Khandesh		14.1	11.6	
Central Provinces		3 to 9	...	
Bombay		6.1	5.3	
Assam Valley.	Cold, 74° and 75°.	6.4	12 to 13	
Chota Nagpore		5.3	4.4	
Punjab (South and West).		2.0	1.0	
Punjab (North-West)	Very cold, below 74°.	3.6	2.0	

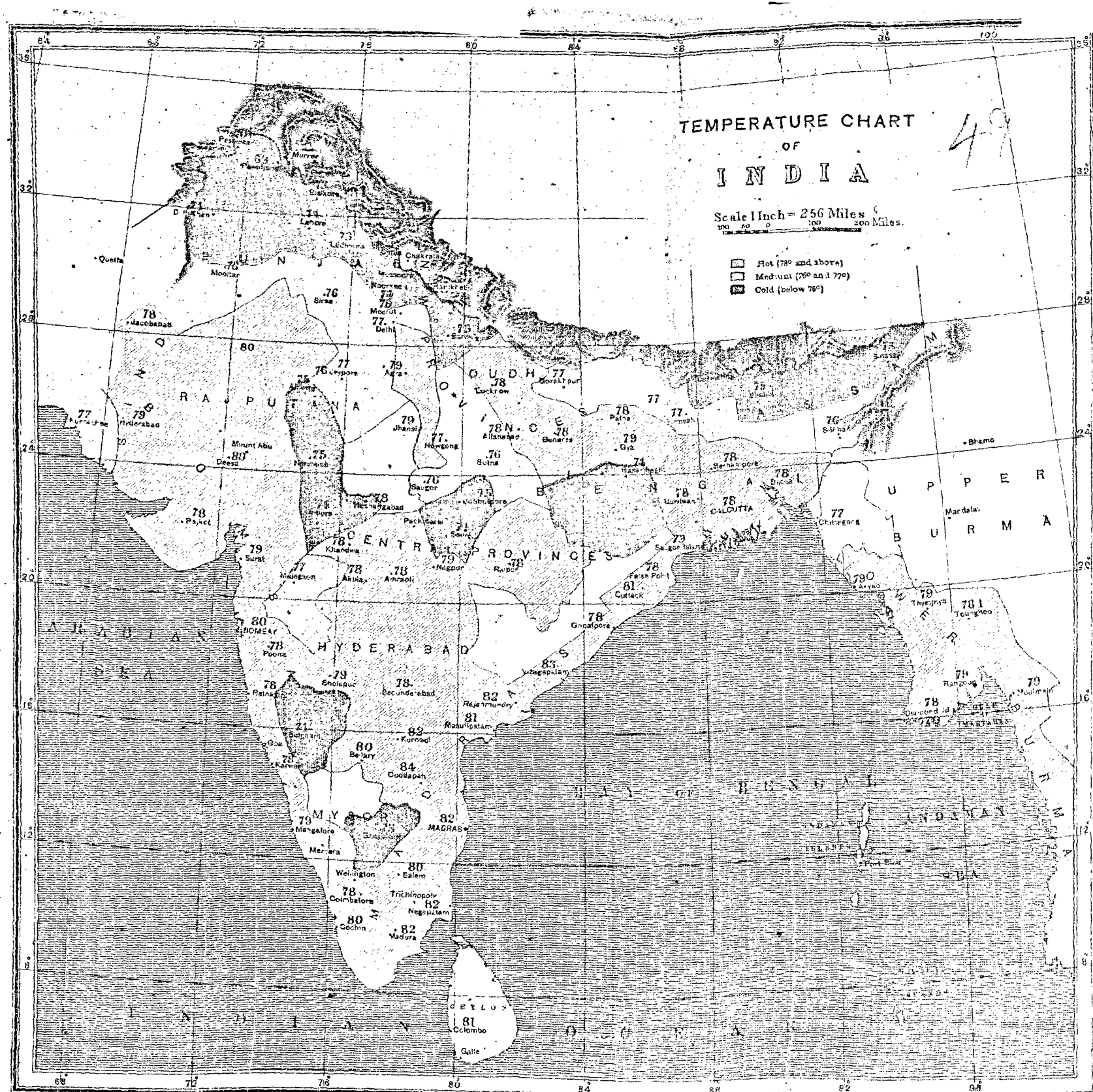


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precarious, except where the land can be irrigated from the rivers. On the other hand, Cachar and Assam are the dampest provinces in India; they have no dry hot season like most other parts of India, and vegetation is green and luxuriant all through the year. Between these extremes the dampness of the climate increases gradually from west to east. Thus Eastern Rajputana, Central India, and the North-Western Provinces are less dry than Sind and the Punjab, and their eastern districts less so than their western; Behar and Chota Nagpore, which lie to the east of these, are still damper, and Bengal much more so, especially its eastern districts and those bordering on the sea. The dampness of the climate increases also everywhere on approaching the Himalaya, and lofty hills are always damper than the plains." 12

Looking at the three leprosy distribution maps, it seems that actually the smallest proportions of lepers are found in the driest areas. Thus undoubtedly there is less leprosy in the Madras districts of the east coast than on the west coast, and in Sind and the South-West Punjab the ratio of lepers to the healthy population is lower than in any other part of India. Again, in Bengal a great amount of leprosy prevails, and it may be said that, in general, passing from west to east an increase in the relative leper population can be easily traced. Of course, it is not maintained that the dryness of the climate is the sole, or even a chief, factor in the numerical distribution of the disease, yet it must always remain a significant and suggestive fact that the leper ratios vary inversely with the dryness of the climate. This is especially well demonstrated by the censuses of 1881 and 1891. Table V is arranged according to the above extract from Blandford's "Geography of India."

(12) H. E. Blandford: op. cit., page 23.



A comparison of the appended map showing the annual mean temperature (in degrees Fahrenheit) with the three leper distribution maps demonstrates clearly that no relation between leprosy and heat can be established, and it will thus be unnecessary to delay any further over this subject.

A table will now be given to show the annual average of rainfall and humidity respectively, and this is further illustrated by a map:—

TABLE VII.

Annual Average Rainfall and Humidity.

Area.	Rainfall.	Humidity.	REMARKS.
South-West Punjab	Below 25 inches, very dry.	Very dry.	
Sind		Dry.	
Rajputana		Dry.	
Central Madras		Medium.	
Khandesh		Dry.	
North-Western Provinces		Dry.	
Oudh	25—40 inches, dry.	Medium.	
Central Punjab		Dry.	
South-Central Madras		Medium.	
Mysore		Damp.	
Bombay		Medium.	
Berar		Dry.	
Central Provinces		Dry.	
Kathiawar		Very dry.	
East Coast (Central)		Dry.	
South Madras		Damp.	

Table VII—continued.

Annual Average Rainfall and Humidity.

Area.	Rainfall.	Humidity.	REMARKS.
Central Bengal . . .	40—60 inches, medium.	Very damp.	
Chota Nagpore . . .		Medium.	
Behar . . .		Damp.	
East Coast (North and South)		Damp.	
East Bengal . . .	60—100 inches, wet.	Very damp.	
Assam Valley . . .			
Deltaic Bengal . . .			
North Bengal . . .			
Orissa . . .	Over 100 inches, very wet.	Very damp.	
Tenasserim . . .			
Burma . . .			
Cachar . . .			
Malabar Coast . . .			

It will now be easy to select the driest areas and districts of India and enquire into their leper ratios. This is done in Table VIII.

TABLE VIII.

Areas with their Leper Ratios, arranged according to Dryness of Climate.

Areas arranged according to dryness.	Leper per 10,000 (Census 1881).	Leper per 10,000 (Census 1891).	REMARKS.
South Punjab . . .	2.7	1.7	
Sind . . .	1.1	.7	
Rajputana . . .	...	1.4	

Distribution of Leprosy.

Table VIII—continued.

Areas with their Leper Ratios, arranged according to Dryness of Climate.

Areas arranged according to dryness.	Leper per 10,000 (Census 1881).	Leper per 10,000 (Census 1891).	REMARKS.
Kathiawar . . .	2.2	1.5	
Central and Western Punjab.	2.0	.75	
Khandesh . . .	14.1*	11.6	* The returns for Khandesh (1881) are probably too high (cf. above.)
North-Western Provinces and Oudh.	4.0	3.6	
Central Punjab . . .	2.4	.9	
Berar . . .	14.0	12.7	
Central Provinces . . .	2.8 to 9.0	...	
Madras Central . . .	2.0	1.8	
South Madras . . .	4.1	2.1	
East Coast (Central) . . .	3.6	2.7	
Mysore . . .	2.6	3.4	
Bombay . . .	6.1	5.3	
Chota Nagpore . . .	5.3	4.4	
Behar . . .	5.7	5.0	
East Coast (North and South).	5 to 6	4 to 5	
Burma . . .	6.9	6.3	
East Bengal . . .	5.6	4.3	
Assam . . .	7.0	12 to 13	
Deltaic Bengal . . .	7 to 19.5	5 to 16.1	
Central Bengal . . .			
Orissa . . .	12.4	11.0	
Malabar . . .	6.3	5.6	

Speaking generally, at either end of this table the extreme ratios are met with, while in the middle the intermediate ones are found. The series is only disturbed by the high proportions of Khandesh and Berar. In the appended map red represents the driest areas, while blue indicates the dampest, and yellow the intermediate ones. By comparing this map with the leper distribution maps a graphic demonstration is given of what has been suggested above, that is, that there is an apparent connexion between the dryness of the climate and a small leper population; for it will be seen that in the four maps the red colours to a certain extent cover the same areas, while blue in the climate map occupies those spaces which in the other maps are darkly tinted, or at least other than red, thus indicating a greater amount of leprosy. Whether this is only accidental it is difficult to say, and perhaps too much importance must not be attached to it. It is not intended to advance any theory on the strength of these observations. Yet the fact seemed significant enough to deserve especial mention, all the more as all three censuses bring out this general principle.

Leprosy and the Increase and Decrease of Population.

On the climate of a country to a great extent depend the health and wealth of the people. It is difficult to get a fair estimate of the comparative healthiness of the various districts of India, for it is impossible to do so by a study of the rates of increase or decrease of the population as registered in the Census Reports. This can in no way gauge with any amount of accuracy the rate of mortality which may be considered a pretty fair estimate of the healthiness of an area. Errors cannot be excluded while arguing in this manner, as the movement of the population depends not only on mortality, but also on many other factors. The observation of Malthus regarding the tendency of the population within a fixed area

to increase faster than the land yields food for it, is well known, and its truth in the present day is fully accepted. Physical and social influences greatly stimulate the multiplication of a people. There is for many parts of this country the tropical climate, necessitating the barest requirements of food and clothing, the extent of cultivable soil, and the religious sanction or social influence that contains within itself all the vitality of the popular belief of the masses: there is lastly the retarding unprogressive form of Indian society which excludes all advance of a standard of comfort from one generation to another. As Mr. Baines writes in his excellent Report on the Census for the Presidency of Bombay¹³: "Under different circumstances the increase in material prosperity may have the result of either increasing or decreasing the population, and it is the same with a decrease in well-being. The difference depends upon whether the standard according to which the people mould their life is that of subsistence or of maintenance. As regards India the special features to be taken into consideration are, first, the sharp and impassable social distinctions, in consequence of which the enterprising man is conscious that, however he may increase his wealth, his station is fixed for him by a barrier he cannot overstep; secondly, the fact that the religious obligation is imposed on all who profess the Hindu religion; thirdly, the place of the standard of comfort is here taken by that of expenditure on the half-social, half-religious ceremonies that are held to mark the performer's place amongst his caste-fellows. The motive of economy is not the desire of permanently ameliorating the position of the man himself or his posterity, but of keeping up appearances for the occasion only."

There is thus in India a large class whose standard of subsistence is of the lowest possible, and who are therefore

⁽¹³⁾ Imperial Census of 1881,—"Operations and Results in the Presidency of Bombay, including Sind," page 29.

Speaking generally, at either end of this table the extreme ratios are met with, while in the middle the intermediate ones are found. The series is only disturbed by the high proportions of Khandesh and Berar. In the appended map red represents the driest areas, while blue indicates the dampest, and yellow the intermediate ones. By comparing this map with the leper distribution maps a graphic demonstration is given of what has been suggested above, that is, that there is an apparent connexion between the dryness of the climate and a small leper population; for it will be seen that in the four maps the red colours to a certain extent cover the same areas, while blue in the climate map occupies those spaces which in the other maps are darkly tinted, or at least other than red, thus indicating a greater amount of leprosy. Whether this is only accidental it is difficult to say, and perhaps too much importance must not be attached to it. It is not intended to advance any theory on the strength of these observations. Yet the fact seemed significant enough to deserve especial mention, all the more as all three censuses bring out this general principle.

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There is thus in India a large class whose standard of subsistence is of the lowest possible, and who are therefore

¹³ Imperial Census of 1881,—"Operations and Results in the Presidency of Bombay, including Sind," page 29.

unusually sensitive to the effects of disease, scarcity, or want of labour. There is an extraordinarily large proletariat living, and such agencies as famine or drought must reduce their numbers considerably. Again, the increased demand for labour removes people from those districts which supply a large portion of unskilled labour, and a large extent of unoccupied fertile land available for cultivation will attract numbers of people, as will also the increase of trade, by opening of railways and so forth.

All this must not be left out of sight in deducing from the rate of increase or decrease of the population the amount of mortality, and establishing from the latter the comparative healthiness of an area. All the Census Reports bring out this fact strongly that no connexion exists between the increase or decrease of the population and the leper ratios. The present enumeration, if an absolute value be attached to the figures, indeed shows that, though the general population has increased, the number of lepers has materially diminished during the last decade. In the Census Reports for the Central Provinces⁽¹⁾ means are given to study the effect of comparative healthiness of a district on the leper ratio. Mr. T. Drysdale has arranged the districts of the Central Provinces in their order of annual rate of decrease, and it will be seen that in some of the healthiest districts there is the largest amount of leprosy, and the converse is also true. This will now be given in a tabular form.

(¹) Census of the Central Provinces, 1881, Vol. I, page 78.

TABLE IX.

Relation between Leprosy and the Comparative Healthiness of the Districts in the Central Provinces (1881).

Districts in the order of comparative healthiness.	Rate of Increase or Decrease in population since last census.	Leper ratio for 1881.	REMARKS.
Nagpur	+ 10'5	12'1	The figures in the second column show that it is impossible to judge as to the comparative healthiness of a district from the rate of increase or decrease of the population.
Wardha	+ 9'16	12'9	
Saugor	+ 7'05	2'9	
Hoshangabad	+ 8'56	6'0	
Damoh	+ 16'06	2'0	
Balaghat	+ 12'85	4'9	
Betul	+ 11'33	3'7	
Chanda	+ 16'16	7'9	
Bhandara	+ 21'06	6'5	
Chhindwara	+ 17'92	4'4	
Seoni	+ 11'37	2'1	
Sambalpur	+ 32'59	7'8	
Jubbulpore	+ 29'95	3'4	
Raipur	+ 28'51	9'7	
Bilaspur	+ 42'2	4'7	
Mandla	+ 41'66	2'7	
Nimar	+ 9'55	8'8	
Narsinghpur	+ 7'59	4'1	

The order of the districts was determined by the rate of mortality, the only available estimate. Such tables could not be obtained for other provinces, but for completeness' sake details will now be given for the province of Bengal and the presidency of Bombay respectively as to the relation between the leper population and the rate of increase of the inhabitants from census to census.

TABLE X.

Relation between Leprosy and the Rate of Increase or Decrease of Bengal (Census 1881).

Districts in the order of rate of increase.	Increase or Decrease in population since last census.	Leprosy Ratios for 1881.	Increase or Decrease in Leprosy Ratios.	REMARKS.
Darjeeling .	+	11.8	+	+ = increase since last census. - = decrease since last census. ± = No change since last census. The increase or decrease has been calculated from the Leprosy Census Returns found in the appendix to this chapter. It will be seen that in a few instances there are discrepancies between the second column of this table and Table II of the various Census Reports for 1881. However here only the population on which the leprosy ratios were calculated could be considered, and this sufficiently explains the differences, which in any case are very slight.
Jalpaiguri .	+	12.9	+	
Mymensingh .	+	8.4	+	
Dacca .	+	5.6	+	
Nuddea .	+	9.4	—	
Bankoora .	+	37.2	+	
Pubna .	+	6.4	+	
Tipperah .	—	4.9	+	
Jessore .	—	4.0	+	
Furreedpore .	+	4.0	±	
Bogra .	+	6.7	+	
24-Pergunnahs .	—	5.1	+	
Howrah .	...	5.6	...	
Khoolna .	...	2.7	...	
Rajshahye .	+	4.6	+	
Chittagong .	+	4.3	+	
Moorshedabad .	—	12.7	—	
Dinapore .	+	7.4	+	
Backergunge .	—	2.5	+	
Midnapore .	—	9.2	+	
Rungpore .	—	14.9	+	
Noakholly .	+	2.6	+	
Burdwan .	—	29.5	+	
Beerbhoom .	+	32.7	—	
Hooghly .	—	11.1	+	

TABLE XI.

Relation between Leprosy and the Rate of Increase or Decrease of Bombay (Census 1881).

Districts in the order of rate of increase.	Increase or Decrease in population since last census.	Leprosy Ratios for 1881.	Increase or Decrease in Leprosy Ratios.	REMARKS.
Upper Sind Frontier	+	1.3	+	Cf. Table X.
Khandesh .	+	14.1	±	
Thar and Parkar .	+	.5	±	
Kurrachee .	+	1.8	±	
Shikarpur .	+	.8	±	
Kolaba .	+	11.3	—	
Thana .	+	8.2	±	
Panch Mahals .	+	2.7	—	
Nasik .	+	7.5	—	
Kanara .	+	1.2	—	
Hyderabad .	+	1.2	±	
Ahmedabad .	+	.8	—	
Kaira .	+	2.4	—	
Surat .	+	6.2	—	
Satara .	—	11.0	—	
Ratnagiri .	—	9.2	—	
Poona .	—	12.0	±	
Ahmednagar .	—	10.1	—	
Broach .	—	2.5	—	
Belgaum .	—	3.3	—	
Dharwar .	—	1.8	—	
Sholapur .	—	6.8	—	
Kaladgi .	—	2.9	—	

These three tables show clearly that from the census reports, the only evidence at hand, no relativity can be established between the amount of leprosy prevailing in a particular district and the rate of increase on the one hand, or the com-

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so in some districts of the Punjab and the Central Provinces. Of all these districts, Bengal, especially Lower Bengal, Assam, Lower Burma, Behar, and the specified parts of the North-Western Provinces and Oudh may be singled out, the last-mentioned being the least visited by cholera.

In the appended Cholera Map of India the endemic areas are tinted dark blue. It will be seen that here the tracts where cholera is always found, and at all seasons, cover a smaller area than those enumerated by Dr. Bellew. The map has been constructed according to a similar one in the Sanitary Commissioner's Reports, and may be taken to express the views generally accepted by Indian medical officers. However, it is only fair to state both opinions, so as to avoid all exclusiveness or prejudice.

A tabular survey will facilitate the study of the leper density in these areas.

TABLE XII.

Cholera and Leprosy.

Districts and provinces in which cholera is endemic, according to Bellew.	Leprosy Ratios per 10,000 (1st Census).	Leprosy Ratios per 10,000 (2nd Census).	Leprosy Ratios per 10,000 (3rd Census).	REMARKS.
Bengal Proper*	7.8	9.4	6.9	* The districts marked with an asterisk are those in which according to the map of the Sanitary Commissioner's Report cholera is endemic. For Assam cf. Table V.
Behar*	3.9	5.7	4.5	
Orissa*	2.4	12.4	11.0	
Assam*	6.8	7.0	12.3	
Burma*	11.6	6.9	6.3	
Southern North Western Provinces	3.3	4.0	3.4	
Delhi	6.6	3.4	1.7	
Amritsar	6.4	3.9	1.5	
Jullundur	11.1	7.6	5.1	
Peshawar	1.9	2.2	1.6	

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immediately before a census may possibly disturb the uniformity of ratios. Thus perhaps it is fairest to argue from the extremes only. These tend to show that, generally speaking, in those districts which, on account of the endemic appearance of cholera, certainly rank amongst the unhealthiest in India, leprosy is very prevalent, while over those areas where there is little or no cholera (which are represented in red) the leper population likewise is smaller. As was explained above, a causal connexion between leprosy and cholera is not hinted at, but it is quite possible that the same noxia which cause one district to be more attacked by cholera than another have also a deleterious effect on the vital powers and general condition of their population in other directions.

Leprosy and Famines.

The great famine which raged over the southern provinces of India no doubt effected grave changes in the population, destroying thousands of lives and reducing the health of the community. The famine extended over the years 1876 to 1878, and attacked especially the Madras Presidency, but partly also Bombay. Taking the former first, according to the Census Report of 1881, there were nine districts which suffered, while the remaining thirteen were spared altogether. But while among the non-famine districts a relative increase of leprosy, according to a comparison of the first two censuses can be established in eight instances, this is only possible in two out of nine of the famine districts. Among the eight unfortunate Bombay districts an increase could not be traced in a single case, but, on the contrary, as in Madras, in the majority of famine districts an appreciable decrease is observable. The loss of population for the southern presidency amounted to 13 per cent. on the previous census, and the population was 18 per cent. below what it ought to have been. It is therefore possible that lepers under such unfavourable conditions died in large numbers, for of twelve districts in the

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Bombay Presidency, in which the leper ratios diminished, seven were struck by the famine, while of nine similar districts in the other presidency six were visited. It is of course impossible to estimate the actual influence of such distressful conditions in this manner, as all the information required regarding the number of lepers who died during those years cannot be obtained, and the recent census throws but little light on this question.

A table is appended to show the possible effect of the famine on the leper population.

TABLE XIII.

Famine and Leprosy.

Presidency.	District.	Leper Ratios after famine (2nd Census).	Leper Ratios before famine (1st Census).	REMARKS.
MADRAS.	Nellore . . .	3.2	3.9	* It appears from the Census Report (1872) that cases of "white leprosy" were generally included under the term "leprosy." The figure in brackets indicates what is probably the true ratio of lepers for Belgaum.
	Cuddapah . . .	1.8	2.9	
	Kurnool . . .	3.4	3.6	
	Bellary . . .	2.6	3.7	
	North Arcot . . .	6.3	6.2	
	Madura . . .	3.7	2.9	
	Salem . . .	2.2	2.8	
	Coimbatore . . .	1.4	2.2	
	Pudukota . . .	2.8	3.0	
BOMBAY.	Broach . . .	2.5	5.3	† In Khandesh and one or two other districts of Bombay in 1881 "white leprosy" was not rigorously excluded.
	Ahmednagar . . .	10.1	14.0	
	Poona . . .	12.0	12.0	
	Sholapur . . .	6.8	11.9	
	Satara . . .	11.0	11.8	
	Belgaum* . . .	3.3	10.0(5.1)	
	Dharwar† . . .	1.8	11.6	
	Kaladgi . . .	2.9	7.4	

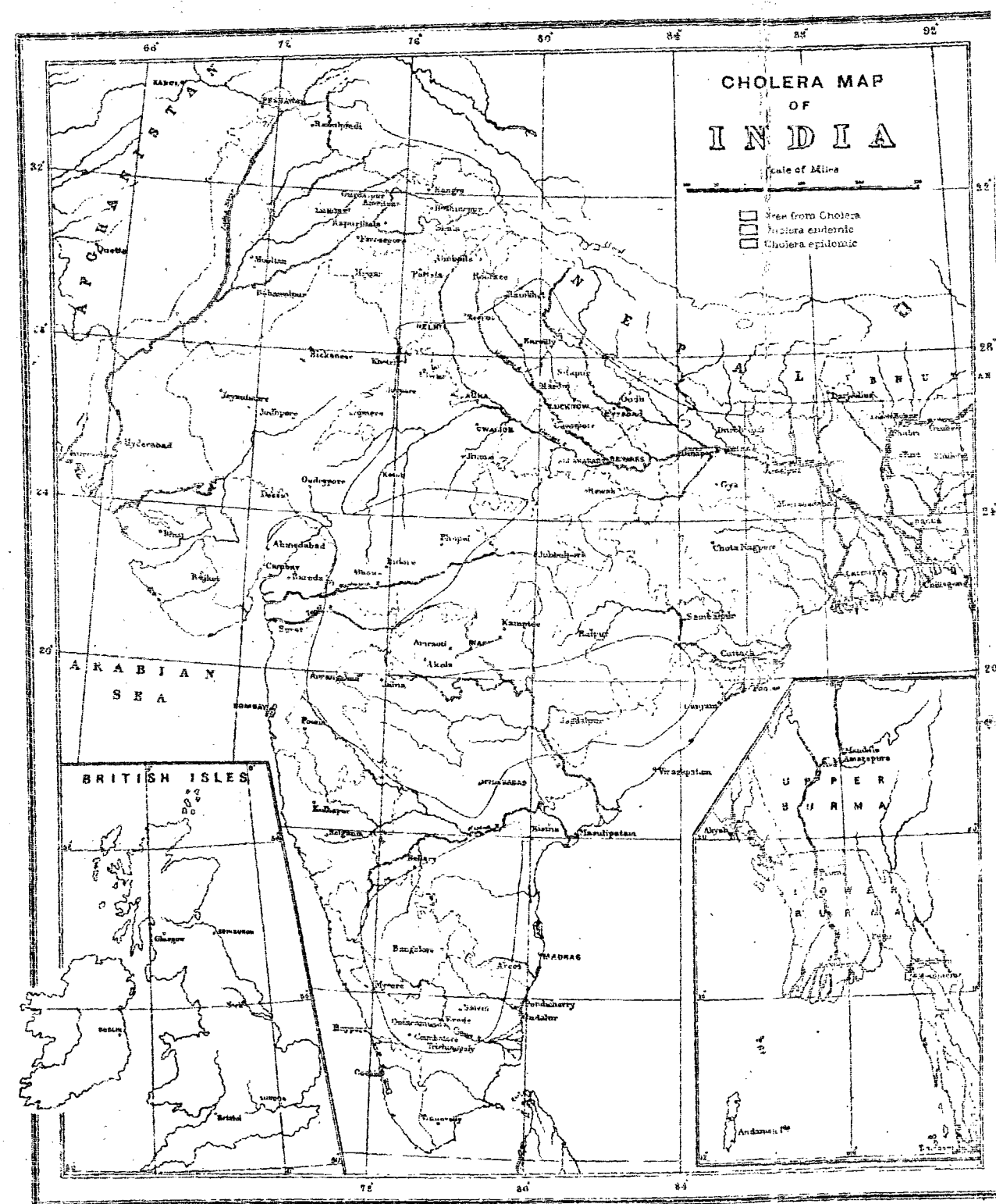
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quently, although subject to regularly recurring periods of epidemic intensity, considered an endemic disease in such regions or tracts of country. In the other class of regions or tracts of country cholera is not found to be always active at all times and seasons. On the contrary, in these areas it prevails only in seasons of periodically recurring general epidemic diffusion of the disease, and consequently cholera in these regions and tracts of country is considered only an occasional visitor and an epidemic disease."¹⁵

Now, as explained above, the areas in which cholera is endemic may be considered unhealthy in a general way, and this unhealthiness will depend to a certain extent on the climatic, geological, and meteorological conditions of such area, the density, prosperity, and general life and habits of the population. In this respect cholera may be assumed to be a better test of the health and wealth of a region than the decennial rate of mortality, which at best must always be an uncertain quantity for a vast country like India, and therefore quite inadequate as a standard of healthiness.

Cholera is endemic in the whole of Bengal, especially in its low-lying districts, with alluvial soil, subject to periodical inundations or water-logging by seasonal floods of the great rivers, with moist and hot tropical and sub-tropical climate. In the whole of Assam, Behar, and Burma cholera is always found. According to Dr. Bellet the disease is endemic in the following districts: the great river deltas of the Ganges and Brahmaputra in Bengal and Assam; of the Mahanadi in Orissa; the interfluvial tracts of Behar; the deltas of the Irrawaddy and Salween in Burma, which means practically the whole of Lower Burma; to a less degree the deltas of the Godavari, Kistna, and Kaveri; the coast districts of Malabar and Konkan; Oudh and the Southern Gangetic districts of the North-Western Provinces as far up as Allahabad, and still less

⁽¹⁵⁾ H. W. Bellet: History of Cholera in India, page 773.



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TABLE XII.—*continued.*

Cholera and Leprosy.

Districts and provinces in which cholera is en- demic, according to Bellew.	Leper Ratios per 10,000 (1st Census).	Leper Ratios per 10,000 (2nd Census).	Leper Ratios per 10,000 (3rd Census).	REMARKS.
Konkan	8.4	9.2	8.3	
Malabar	6.0	5.1	4.4	
Godavari	4.1	5.8	4.6	
Kistna	3.5	4.0	2.6	
Tanjore	7.2	5.0	3.1	
Trichinopoly . .	2.8	4.0	2.3	
South Arcot . .	4.8	6.6	4.7	

It will be seen from this table that from a consideration of the three censuses the highest leper ratios are obtained in Bengal, Orissa, Assam, Burma, and Konkan, and of these the first four are the most choleraic districts in India. Considering Bengal alone, the highest ratios are found in Burdwan, Bankopra, Beerbhoom, Hooghly, Moorshedabad, Rungpore, in all of which the health, as estimated by the prevalence of cholera, is exceedingly bad, the Burdwan District being perhaps the worst in this respect. The leper ratios of Bengal, Burma, Assam, and Orissa are among the highest in the empire, and in Madras those of the choleraic districts are higher than those of cholera-free areas, with the exception of Kistna and Trichinopoly. Cholera, however, is not exceptionally virulent in this presidency. The ratios for Konkan are very much above the averages for Bombay, and Jullundur has the densest leper population in the Punjab.

It is only possible to argue on broad lines, and all exclusiveness must be carefully avoided. Here, as in the rest of this chapter, the great difficulties which necessarily exist in a survey of so large a continent are keenly felt, and all that

Distribution of Leprosy.

is said must merely be taken as suggestions worthy of future consideration. It seems, however, that in those areas and regions in which cholera is worst and endemic, the leper diffusion is also greatest. The facts concerning Lower Bengal, Assam, and Burma, which are the worst fever districts of India, and at the same time, taken as a whole, the most afflicted with leprosy, may suggest that causes exist here which lower the health and vitality of the population, and thus predispose it towards this disease. The special agents concerned in the development of cholera are manifold: climate, poverty, overcrowding amongst them. But all these must contribute to a bad hygiene and diminished resistance against infective processes. It may be assumed that where cholera is worst the hygiene and physical powers of the people are lowest. If this be so, and Burma, Lower Bengal, Assam, and Orissa, on the strength of this, considered hygienically the most unsound districts, this fact may be accepted amongst others to explain the great amount of leprosy in such districts as Burdwan, Assam, and Burma.

A comparison of the leper distribution maps with the cholera map will still further illustrate this matter. The dark blue area in the latter represents those regions where the disease is strictly endemic, while over the lighter areas the disease is rather an epidemic than a constant feature. It will be seen that the districts of Burdwan, Beerbhoom, Midnapore, Moorshedabad, Darjeeling, Jalpaiguri, Rungpore, Sylhet, and Cachar, in which leprosy prevails most extensively, are all situated in the area of endemic cholera. And though the statement is subject to exceptions, it may be said that more or less the dark blue areas on the cholera map correspond to those tinted other than red in the leper distribution maps. An absolute harmony, even if this theory hold good, cannot be expected, especially over those tracts where cholera is hardly endemic, as here the conditions responsible for an outbreak are not constant. Again, as will be shown later on, a famine

In estimating the value of these figures too much importance must not be attached to a small increase or decrease, but ratios which differ but little must be considered as representing a persistence of former conditions, since an increase or decrease of less than one in ten thousand is practically inappreciable, and moreover may easily be explained by unavoidable errors in any large enumeration. In Madras, therefore, the leper population can hardly be said to have changed. Here, however, a famine occurred also in 1865 and 1866, and thus matters may have been equalised. The difficulty of arguing from census statistics must not be lost sight of, and due allowance be made for errors in observation and enumeration.

Again, in the year 1866 there was a severe famine over Lower Bengal. During this year throughout Orissa the average price of rice, the staple food of the population, varied from thirteen seers in January to five seers, and even less than five seers, in August. The famine was confined to the districts of Manbhoom, Singbhoom, Bankoora, Nuddea, Midnapore, and the 24-Pergunnahs, in which it was less severe, and was most intense in Orissa. The failure of the harvests for three successive years, especially in Orissa and Tirhoot, and the high price of food in consequence thereof, had made the distress still greater, so that in some parts the poorer classes were reduced to living on the seeds and berries of wild trees, grass, and herbs. That understraitened conditions, as are implied by a famine, the leper has but little chance of survival is highly probable. Up to 1871, and even to 1881, the price of food remained high over Bengal, so that the comparative health of the people was kept at a low standard, and if bad conditions of life have any influence on the development of leprosy, there should be an increase in the leper ratios after they had presumably been greatly reduced by the severe famine of 1866. Comparing the census returns for 1872 and 1881, it is found that in the first census after the famine the ratios were comparatively low, in any case, with the exception of Gya, lower

than in 1881, while in the latter year in many regions there was a remarkable increase. One explanation which suggests itself is, that the severe distress of 1866 and the previous years decimated the lepers, while the unfavourable conditions during the next ten years affected the population in such a manner as to make it more liable to contract leprosy.

The following table gives the districts of Lower Bengal which suffered from the severe famine in 1866 and the leper ratios for the first two censuses. The difference in the ratios, even allowing for imperfections in the enumeration, is remarkable. With regard to Gya it must be remembered that some parts of this district suffered much less than others, and that the famine practically raged only in the western and southern parts:—

TABLE XIV.

Famine in Lower Bengal and its Effect on the Leper Ratios.

DISTRICT.	Leper Ratios per 10,000 (1st Census).	Leper Ratios per 10,000 (2nd Census).	REMARKS.
Bankoora	29.9	37.2	* Only parts of Gya suffered from the fa- mine.
Bhagalpur	3.1	5.0	
Champaran	2.1	3.6	
Gya*	9.8	9.5	
Manbhoom	5.4	12.3	
Midnapore	8.3	9.2	
Monghyr	3.0	5.4	
Nuddea	9.7	9.4	
Orissa	2.4	12.4	
Sarun	3.3	5.4	
Shahabad	6.0	8.2	
Singhbhoom	3	4.7	
Sonthal Pergunnahs .	4.0	5.0	
24-Pergunnahs . . .	4.0	5.1	

their geographical features, are exempt from the risk of drought and consequent famine, are: (1) the eastern districts of Bengal and Assam, which enjoy so ample and regular a rainfall and such abundant river inundation as to ensure the safety of crops in the driest years; (2) Burma, which, like Eastern Bengal, is never without rainfall or inundations more than sufficient for its luxuriant rice crops; (3) the narrow strip of country lying between the Western ghats and the sea, and the tract immediately eastward of the summit of that range; (4) the upper valley of the Nerbadda; (5) Sind, in which, owing to the very small rainfall, agriculture almost wholly depends on artificial irrigation from the Indus, the supply of water from which never so far fails as to cause a general loss of crop."¹⁶

A map is appended to exhibit these tracts. These are tinted red, while blue represents all those visited by famine since 1860, the dark blue having suffered at least twice, the North-Western Provinces alone having been subjected more than twice to such distressful conditions since that time. The numbers indicate the years in which famines visited the respective regions.

The following table will assist to elucidate these points:—

TABLE XV.

Famine and Leprosy.

PROVINCE.	Famines.	Leprosy Ratios (per 10,000 (1st Cen- sus).	Leprosy Ratios (per 10,000 (2nd Cen- sus).	REMARKS.
ASSAM*	No famines	6.8	7.0	* As Assam included certain districts in 1881 which at the previous census were incorporated with Bengal, the ratio 6.8 has been calculated on an area equal to that of 1881.
BENGAL PROPER	Very intense famine in 1865 and 1866	7.8	9.4	
BERAR	No famines	6.4	14.0	

(¹⁶) Report of the Indian Famine Commission, Part I, page 8.

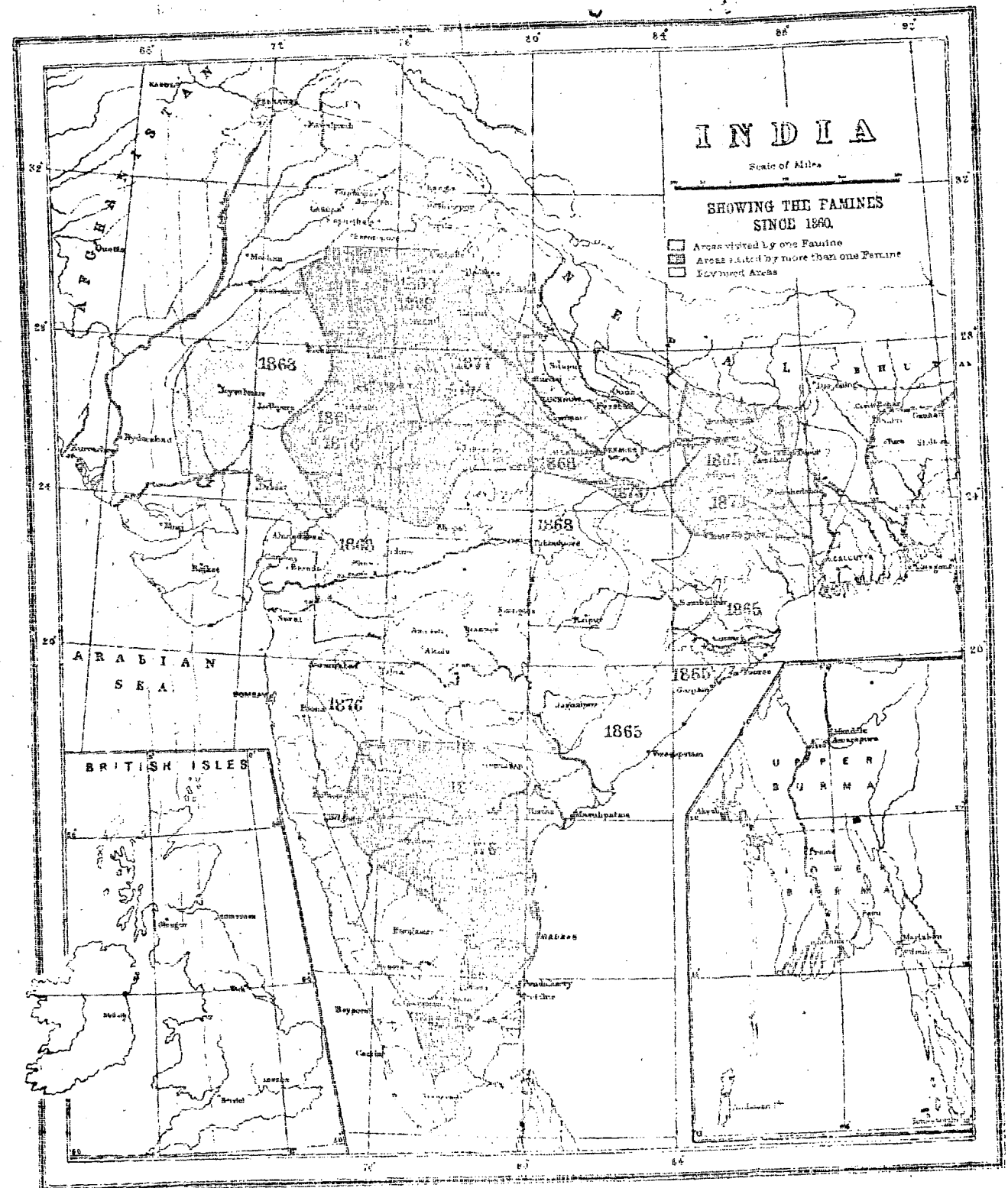
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Discussing this question more generally, it will be found that a famine, shortly before a census, apparently has a tendency to reduce the leper ratio for such province, provided that the census returns are considered sufficiently accurate. The enumerations occurring only once in every ten years, it is impossible to check the figures in anything like a satisfactory manner. Hence in all arguments two courses are open, *viz.*, either to discredit the value of the ratios altogether, or to concede to them a relative value of fairly sufficient accuracy. If the former view be taken all the preceding and following deductions are not worthy of consideration. If within certain limits they are regarded as a more or less true comparative statement of the leper diffusion, then it is necessary to explain the differences in the ratios over different areas and in successive censuses. For the present considerations and deductions, the latter more optimistic view has been taken, leaving it, however, to the option of others to choose between the two alternatives.

In the Central Provinces there was severe distress during the years of 1868 and 1869, while in the period between the first two censuses no scarcity occurred. It is found that in 1872 the leper ratio amounted to only 2.7, as against 6.5 in 1881. In the Bombay Presidency an intense famine raged for two years shortly before the second enumeration, and the leper proportion in 1881 was 2.4 per ten thousand less than in 1872.

In the North-Western Provinces a severe famine passed over the districts in 1868 and 1869, and a less severe one in 1877 and 1878; and it is seen that the ratios remained low and nearly equal for the two censuses, and the same applies to Madras with its famines of 1865 and 1866, and 1876—1878, respectively. On the other hand, in Berar, where there has been no famine, the proportions were high on both occasions, especially so in 1881.

"The parts of the country which, from the abundance and certainty of the rainfall, or from other conditions of climate, or



Litho. S. I. O., Calcutta.

Reg. No. 456, Leprosy Com.—Sep. 91.—310.

Reg. No. 456 R, Leprosy Com.—Mar. 92.—1,504.

TABLE XV.—*continued.**Famine and Leprosy.*

PROVINCES.	Famines.	Lepers Ratios per 10,000 (1st Census.)	Lepers Ratios per 10,000 (2nd Cen- sus).	REMARKS.
BOMBAY . . .	Very intense famine, lasting for two years 1876 to 1878 . . .	8.5	6.1	
CENTRAL PROV- INCES.	Very intense famine, lasting for two years in 1868 and 1869 . .	2.7	6.5	
MADRAS	Famine in 1865 and 1866 . . .	4.4	4.7	
	Very intense famine from 1876 to 1878 . .			
NORTH-WEST- ERN PROVIN- CES AND ODH.	Scarcity in 1860-61, lasting one year . . .	4.2	4.0	
	Intense famine in 1868 and 1869, lasting two years . . .			
	Scarcity in 1877 and 1878, lasting one year . . .			
PUNJAB	Scarcity in the south- east in 1860 and 1861, lasting one year .	6.2	3.6	
	Intense famine in the south-east in 1868 and 1869, lasting two years . . .			
	Scarcity in the south- east lasting for one year in 1877 and 1878 . . .			

At first sight the Punjab appears to be an exception to the above assumption that a famine before a census possibly causes an appreciable diminution in the number of lepers. But it must be remembered that here the first census took place in 1868, so that the more intense famine worked its effect on the leper population after the enumeration. This famine was very severe in Hansi, Hissar, Rohtak, and Karnal districts,

and the distress was exacerbated by the "intensity of famine" over so great an area as that of Rajputana, which raised prices to an excessive height and drained away the diminished food-stocks; while the influx of emigrants from those parts added to the severe strain on the charity of the public. Distress was so intense that 23,000 received gratuitous relief daily for nine months at a cost of Rs. 4,250,000, and about three lakhs of rupees of land revenue were remitted. The mortality was greatly in excess over that of previous years." Of the famine in 1877-78 the Report of the Famine Commission¹⁷ says "that the failure of the monsoon of 1877 was very complete in the Punjab, but the autumn crop is less important there than in any other part of India, and the rain of October made it possible to sow the usual area with spring crops. Moreover the preceding years had been very prosperous, and the export of wheat, which had greatly increased in the years 1876 and 1877, brought large sums of money to the province. The scarcity, however, became serious in some places through the height to which prices had risen in consequence of the famine of the south, and by reason of the influx of starving people from Kashmir. The parts which suffered most from the drought were those districts of the Delhi and Hissar Divisions not protected by the Western Jumna Canal which are always among the first affected, and the hill district of Hazara, which had not been known to suffer in any earlier famine. The distress was, however, nowhere intense; the ordinary measures were taken to supply relief, and with the rains of 1878 all fear of famine passed away. The mortuary returns, however, which indicate an excess mortality of about 340,000 above the average during the year 1878, afford reason for fearing that the high prices had a grievous effect on the poorer classes of the population." It will thus be seen that the Punjab forms no exception to the opinion expressed above,

(¹⁷) Report of the Indian Famine Commission, Part I, page 15.

(¹⁸) Ibidem, pages 20 and 21.

that a famine before a census may possibly affect the relative diffusion of leprosy over a given area, and this point must not be left out of sight in the study of the ætiology of the disease by a comparison of the density of the leper population in various presidencies or provinces. During seasons of distress, such as it is perhaps only known in India, life is reduced to a struggle for existence, and herein the leper must succumb quickly, partly on account of his own miserable condition, partly on account of the poverty of his fellowmen, which compels them to withhold the helping hand. All these considerations demonstrate the difficulties of an enquiry into the relative frequency of leprosy in a country of such vastness as India, subject to periodical calamities altogether unknown in Western Europe, and capable of destroying large numbers of people in a short time. And they also show that those who argue implicitly from census figures must not lose sight of any cause or event which may materially affect such figures and thus decrease their comparative value. Those who realise these points will exercise forbearance with the Commissioners with regard to the many shortcomings in the report, and especially in this chapter, where India is discussed as an unit: they will also understand why matters of great importance have only been alluded to, and all arguments kept on the broadest lines, in many cases being suggestions and hints rather than deductions.

To recapitulate: the purport of these considerations was to show that it is not sufficient to compare two provinces of different leper ratios and then, by a contrast of the physical, economic, and other conditions of these provinces, suggest one particular feature which is found in the area with the higher ratio, as an ætiological factor. When such large tracts are dealt with, the ratios alone are not sufficient to allow of deductions being made as to the proneness of a district to leprosy. Firstly, the size of the Indian provinces demands great caution in all conclusions and arguments. If it be remembered that

Bengal is almost as large as Spain, that the Punjab, and the North-Western Provinces, respectively, occupy only 15,000 and 18,000 square miles less than the whole British Isles, and that Bombay covers an area nearly twice as great as Great Britain and Ireland, an idea may be formed of the difficulties, it might almost be said futility, of drawing general deductions. Secondly, districts must be selected where such interferences as severe and intense famines can be excluded, and more or less equally situated areas should be contrasted.

It now remains to examine how far the above statements are borne out by the present census. Since the great famine in 1876 and 1878 no great distress has occurred in any part of India. The conditions have changed much since that time; railways have been opened all over the country and inter-communication is greatly facilitated; a famine relief fund has been inaugurated to prevent a recurrence of such disaster. Prices and wages are being equalised all over India, and it is certain that the personal condition of the population is bettering itself from year to year, partly on account of increased commerce within and without, partly on account of an improved hygiene. There can be no possible doubt that thanks to the foresight and care of the Indian Government a repetition of the disasters of 1866 and 1876 need not be feared, and that the general conditions of people at large are greatly ameliorated. Sir William Hunter^(*) discusses this question well in his usual eloquent style. He writes: "The increased material prosperity of the people, the growth of foreign trade, the inter-communications with town life, and the opportunities these give for better and more varied subsistence, must have wrought beneficial changes in the population. Then again the gradual spread of western knowledge, education, and sanitary reformation visible in all parts of the country must contribute towards an improvement. The improvement in means of communication, by the construction of railways and metalled

(*) Imperial Gazetteer, Volume VI pages 593 and 594.

roads, has directly developed internal, no less than foreign trade. Facilities for rapid carriage tend to equalise prices, not only over large areas of country, but also over long periods of time. As wheeled carts supersede pack-bullocks, and as railroads supersede carts, the whole of India will gradually become one country for the purposes of food supply. It is by this means alone that a guarantee can be provided against the ravages of famine.

"The vicissitudes of a tropical climate will always cause local failures of the harvest, whether by drought or by flood, which science, indeed, may learn to foresee, but which no practicable schemes of irrigation or embankment can altogether avert. But India as a whole has never yet been unable, in any single year, to yield sufficient food for her population. The real problem of famine is a problem of distribution.

"In former times the inhabitants of one district might be perishing of starvation, while plenty reigned in a district but a hundred miles distant. In 1866 the people of Orissa were decimated, not so much by drought or by inundation, as by the impossibility of transport. In 1877 the distress in Madras was alleviated by the importation of nearly one million tons of grain, all of which was carried inland by two lines of rail in twelve months. Supplies were drawn, not only from the seaboard of Bengal and Burma, but from the most remote provinces. In the year 1877-78 the Central Provinces exported grain to the amount of more than three hundred thousand tons, and the Punjab to the amount of four hundred thousand tons, all of which were conveyed south by rail. Trade has never known such a stimulus as was afforded on this occasion when the carrying power proved barely equal to the strain. If the famine had happened before the opening of the railway it would have resulted in a loss of life without parallel, even in the annals of India.

"But the utility of local trade is not to be judged of only at such a crisis. In normal seasons it tends alike to regulate prices and to promote a higher standard of comfort. Within the last twenty-five years the cultivators have learnt, for the

first time, the real value of their produce. In the old days little was grown beyond grain crops for the year's food. The slightest failure meant local distress, while a bumper harvest so depreciated the value of grain that part of the crops was often left unreaped to rot in the fields. In 1880 and 1881 a suspension of revenue had to be granted to the district of Sylhet because the harvest was so bountiful that it would not pay the cost of carriage to market, and consequently the farmers had no means of obtaining money. Even so late as 1873 the Collector of Rungpore reported that 'the yield of rice was considered too good by the rāyats, as prices were there by kept down.' The extended cultivation of staples for export, such as cotton, jute, and oil-seeds, together with the substitution of more valuable crops for the inferior grains, is now modifying the entire system of Indian agriculture. Land is not being withdrawn from food crops to any appreciable extent, but the rāyat is everywhere learning to cultivate high-priced subsidiary crops which will help to pay his rent."

These changes in the well-being of the people are becoming more visible from year to year, and the general condition of the population has improved considerably during the last decade. Applying the results of the present census to this enquiry into the possible effect on the leper density of a famine, it will be seen that there is an almost general decrease of leprosy all over the country. It is thus not necessary to encumber this chapter with further statistics and tables.

What conclusions may be drawn from this change with regard to the question under discussion? Two courses plainly are open. Firstly, it may be claimed that from a comparison of census figures no legitimate deductions can be drawn, as it is impossible to gauge the correctness of diagnosis and enumeration. Any argument based on a comparison with the recent census especially may be questioned, as this year errors were excluded as rigorously as possible. Again the decrease in the leper population in the majority of famine districts,

according to this last enumeration, may be said to destroy the whole value of the above suggestions. Secondly, those who, after making due allowance for errors, attach more value to census figures may assert that with the improvement of the condition of the people a diminution of leprosy has taken place. The latter, however, as explained above, must not be considered to be so large as the figures seem to indicate, the census on the present occasion having been taken much more critically.

Poverty and Leprosy.

Undoubtedly leprosy attacks the poor and destitute much more frequently than the rich and prosperous, not that the latter are spared altogether, but they certainly suffer to a far less degree. Again good nourishment and care are most important agents in the treatment of the disease, ameliorating the general, as well as the local, conditions of the patient, and keeping the destructive processes in abeyance. It may thus reasonably be asked, whether or no the leper ratios vary with the material prosperity of the masses. It is not sufficient to compare two provinces or presidencies with each other, as the areas are too vast, and thus the conclusions and statement too general. The best mode of procedure which suggests itself is to examine the various districts of several provinces, and subsequently select those regions where leprosy is highly prevalent, and enquire into their economic conditions, and conversely investigate, in like manner, those tracts which present the smallest leper population according to all censuses.

It is extremely difficult to obtain accurate data regarding the relative prosperity of Indian districts. The whole empire being, generally speaking, overcrowded, and the areas of cultivable land insufficient for the large masses of an agricultural population, shows everywhere the most unmistakable signs of poverty, as the term would be understood by western nations. India cannot be called a rich and prosperous country, but

there are great differences in this respect as regards the various districts. The wealth of a country, besides other standards, must be estimated by the area and revenue returns, the density of the population, the trade and wages, food-supply, and the support that it can offer to the increasing population. This implies a special knowledge and a long experience, such as cannot be gained by a temporary stay in India. But even all these data cannot supply absolutely correct information regarding the wealth or poverty of the masses.

Since more than two-thirds of the population of India are supported by cultivation, the best mode of judging the condition of the people is an enquiry into the agriculture and products of the various provinces. "The cultivation of the soil forms the occupation of the Indian people in a sense which it is difficult to realise in England. As the land-tax forms the mainstay of the imperial revenue, so the 'ráyat,' or cultivator constitutes the unit of the social system. The village contains many members besides the cultivator, but they all exist for his benefit, and all are maintained from the produce of the village fields. Even in considerable towns, the traders and handicraftsmen frequently possess plots of land of their own, on which they raise sufficient grain to supply their families with food. The census of 1881 returned a total of 51,274,586 males as engaged in agriculture throughout British and Feudatory India. Adding to these seven and a quarter million of adult day labourers, there is a total of upwards of fifty eight and a half million persons directly supported by cultivation, or 72 per cent. of the whole male population engaged in some specified occupation. The number of persons indirectly connected with agriculture is also very great. The Famine Commissioners estimate that 90 per cent. of the rural population live more or less by the tillage of the soil. India is, therefore, almost exclusively a country of peasant farmers."¹⁰

(¹⁰) Imperial Gazetteer of India, Vol. VI, page 482.

On such a population, imbued with fixed prejudices, the increase of population must have a great influence, and this is noticed in the development of a large landless class. "The cultivated area no longer suffices to allow a plot of land for each peasant; and multitudes now find themselves ousted from the soil. They earn a poor livelihood as day labourers, and, according to the census of 1881, comprise 7,248,491, or one-eighth of the entire adult male population. There is still enough land in India for the whole people, but the Indian peasant clings to his native district, however over-crowded. Migration or emigration has hitherto worked on too small a scale to afford a solution of the difficulty."⁽¹⁾

No connexion can be traced between the density of the population taken by itself and the amount of leprosy in a district, and in like manner, a dense rural population does in no way predispose an area to the disease. This is fully borne out by the census reports, and it will not be necessary to add further statistical proof.

In estimating the material prosperity of the various provinces, general impressions and the experience of Government officials most familiar with the country must be the guides of argument. Information as accurate as possible was obtained from the area and revenue returns, and from facts supplied by Mr. J. A. Baines, Imperial Census Commissioner, Mr. J. E. O'Connor, Assistant Secretary of the Government of India in the Department of Finance and Commerce, and others. Yet the following remarks can only be general, and are intended chiefly to suggest a line of enquiry into the ætiology of the disease worthy of the consideration of those who, through long continuous residence, are in a position to make themselves more familiar with the economic conditions of the empire.

Bengal is, as regards natural resources, the richest and most productive as well as the most populous province of India.

⁽¹⁾ Imperial Gazetteer of India, Vol. VI, page 483.

⁽²⁾ *V. infra.*

With but few exceptions the whole of the Bengal plain is richly cultivated. Chota Nagpore and a part of Southern Behar are elevated and hilly, and up to the middle of this century the whole of this country was a very wild tract of hill and forest, and Chota Nagpore is still so in a great measure. Assam, though in possession of fertile soil, must be considered poor, with large areas of unreclaimed land, being backward and inaccessible, and with very deficient means of inter-communication. "Upper Assam is still mainly either forest or marsh with gigantic grass; the latter to a width of from six to twenty miles on the borders of the river, the former on the higher ground and the adjacent hills. The marsh land when cleared is converted into rice fields, and tea-gardens are established in clearings in the forest, but these are of insignificant extent in proportion to the unreclaimed land."⁽²⁾ The North-Western Provinces and Oudh are next to Bengal Proper the richest and most populous tracts of British India. "There are but few portions of country that are not capable of yielding two crops annually to the tillage of its industrious peasants."⁽³⁾ Judging from the absence of severe famines in most parts of the territory the Central Provinces must be considered prosperous. "The Wardha valley produces some of the finest cotton in India; the Nerbadda Valley in the cold season is a vast spread of wheat and pulse crops, and the Chhattisgarh plain, the granary of Central India, is equally prolific of rice and wheat. The forests yield valuable teak and sal timbers, bamboo, stick-lac for the manufacture of lac, gum, and dye, tusser silk, and tanning materials."⁽⁴⁾ Burma again is very fertile and never subjected to such distressful conditions as scarcity or famines. It is difficult to speak in general terms about Bombay and Madras. In any case these few remarks show that through a consideration of this nature, on such

⁽²⁾ H. E. Blandford. Op. cit., pages 94 and 95.

⁽³⁾ H. E. Blandford. Op. cit., page 71.

⁽⁴⁾ H. E. Blandford. Op. cit., page 121.

general lines, nothing is gained. Between the natural richness and fertility of a province and the leper population no connexion can be traced. From them also the material prosperity of the masses cannot be deduced. With regard to the former point it will be seen that in the richest province, Bengal Proper, the leper ratios are very high; in the Punjab and the North-Western Provinces below the average. But when such factors as famines, scarcity, density of population, decrease of labour and wages are taken cognisance of, it will at once be seen that the natural capability of an area to support its inhabitants cannot be a test of the well-being of the people.

Leprosy is undoubtedly a disease which affects the masses more than the wealthy. It may be impossible to give statistics proving this statement beyond all doubt, but nevertheless, for India at least the fact exists, and the most exclusive contagionist would hardly venture to deny this. It may be asked whether those districts where the disease is commonest are also the poorest. Leprosy is undoubtedly most prevalent in Bengal Proper, and especially so in the Burdwan, Bankoora, and Beerbhoom districts of the Burdwan Division. Now, as regards agricultural conditions, Bengal is the richest province in India, and Burdwan in this respect not inferior to other divisions in the presidency. But the material prosperity of an area cannot be gauged in this manner. It must be remembered that Bengal has the greatest specific population, about four hundred and seventy per square mile, that the three districts are likewise overcrowded, four hundred and fifty—five hundred per square mile. Though the soil is most fertile and the crops most abundant, the proletariat is great and the land cannot supply food for all. Besides, these districts are most unhealthy, cholera and malarial fevers being endemic here. This may explain to a certain extent the great prevalence of leprosy.

"The natural drainage is extremely deficient, and it is difficult to establish any artificial system. The result of the climate is a population and vegetation rank and luxuriant, and

earth and air charged with decaying animal and vegetable matters. Life under such conditions must be unstable, and the quickly matured man must in every stage of his growth and decadence, even under the most happy circumstances, maintain a state of health perilously liable to become one of disease."²⁶ Cholera and fever are the chief causes of mortality amongst the inhabitants of Bengal. "Insanitary conditions abound throughout rural Bengal, and have been only partially dealt with in the better class of towns. The dwellings of the poor, sessile on damp ground, are crowded, and if perchance clean within are surrounded by dirt-heaps and dirt-pools. Clothing is deficient, often dirty; the food is largely composed of unwholesome material, and too generally is insufficient for the needs of the body, and the water is impure. Want, ignorance, and carelessness, or fatalism result in neglect of precautions against disease"²⁷ Dr. Coates describes the population as "poor, ill, and insufficiently clad, badly fed, debilitated, and broken down in constitution."²⁸ In the Chittagong Division the people are, for Bengal, an healthy and able-bodied race, thrifty and industrious, and in a condition of considerable prosperity, and here the smallest leper ratio of any Bengal division is found. Again in Rungpore the tracts where leprosy is extremely prevalent are characterised by marshy and uncultivable land, the people being of lazy habits and living in wretchedly built mat or grass huts, and miserably clothed. On the other hand, the areas of comparative immunity are extensive local plains covered with paddy, the inhabitants given to other pursuits besides agriculture. Trade here is pretty active, rice crops being abundant and exported to a great extent, while the people themselves are more civilised, feed and clothe themselves better."²⁹

(²⁶) F. N. Macnamara. "Himalayan India, its Climate and Diseases," page 127.

(²⁷) F. N. Macnamara. Op. cit., page 129.

(²⁸) F. N. Macnamara. Op. cit., page 130.

(²⁹) F. N. Macnamara. Op. cit., page 209.

Assam is a poor district, and the population, besides being exposed to unhealthy climatic and telluric conditions, live in poverty. Labour has to be imported, and the prices of food are high. The most prosperous districts of Assam are Darrang and Nowgong, and here the leper population is comparatively scanty. Burma also, though extremely fertile and never visited by famines, cannot claim prosperity for her inhabitants. The Burman lives from hand to mouth, in poor sanitary conditions, and surrounded by filth. Peace and enterprise have worked considerable changes; a great improvement is visible all over British Burma, and with the opening up of railroads a further progress undoubtedly will take place. The leper ratios for Burma are high for the first two censuses, but a marked decrease has taken place since the first enumeration.

The hill tracts are the home of an exceedingly poor people, living as a rule in filthy and unhygienic conditions, working as day labourers or coolies. It has been shown above that leprosy is common in these districts. In some of these immigration of lepers may account for an excessive ratio, but this is excluded in others, and no doubt the disease is particularly common in the Himalayan tracts.

The Punjab and North-Western Provinces, considered as a whole, are prosperous tracts. Here leprosy is not very prevalent, as compared with the rest of India. In the Bombay Presidency the smallest ratios are found in Sind. Here the climate is dry with extremes of temperature, the population omnivorous, and this division contains a considerable area of cultivable land, producing more than is required for the support of the existing population. Kaira, Broach, Dharwar, Kanara, Khandesh, Ahmedabad, and Belgaum, considering all things, are about the most prosperous areas, while Ratnagiri, Kaladgi, Ahmednagar, Sholapur, Satara, and Thana are perhaps the poorest. Comparing the leper ratios of these two groups it will be seen that the more prosperous areas, on

an average, have the smaller ratios. This will be shown in tabular form.

TABLE XVI.

Prosperity and Leprosy.

DISTRICT.	Ratio of lepers per 10,000 of population (1872).	Ratio of lepers per 10,000 of population (1881).	Ratio of lepers per 10,000 of population (1891).	REMARKS.
BOMBAY PRESIDENCY.				
<i>A.—Poorest Districts.</i>				
Ratnagiri	12.1	9.3	9.7	
Kaladgi	7.4	2.9	4.1	
Ahmednagar	14.0	10.1	7.8	
Sholapur	11.9	6.8	8.0	
Satara	11.8	11.0	12.1	
Thana	8.3	8.2	6.1	
<i>B.—Prosperous Districts.</i>				
Kaira	5.2	2.4	1.3	
Broach	5.3	2.5	2.2	
Dharwar	11.6	1.8	2.0	
Kanara	3.9	1.2	.4	
Khandesh*	14.8	14.1	11.6	* Cf. previous remarks on Khandesh for 1881.
Ahmedabad	2.9	.8	1.0	
Belgaum†	10.0(5.1)	3.3	3.3	† Cf. previous remarks on the leper census for Bombay (1872).

It will be seen that, broadly speaking, the ratios under (A) are higher than those under (B). An absolute harmony cannot be expected, even if the present theory be correct, as all figures depend on the uncertainty of a general enumeration, however slight the errors for a particular district may be; again famine may, as was above suggested, reduce the ratios; and, thirdly, it is only possible to estimate the well-being more or less approximately. In Kaladgi a great difference is noticed between the ratios of 1871 and 1881, but perhaps this is explained by the ravages of the great famine. Khandesh

has good soil and rainfall, but is not yet opened out and grows bad cotton; and the conditions of Ahmedabad are variable, having part of the richest and also part of the least prosperous land of the presidency.

With these remarks this sketchy review regarding the possible relation between the density of the leper population and poverty must be concluded. A table is added wherein the districts of Bengal are arranged according to their prosperity. The required information has been gathered from Sir William Hunter's Statistical Account of Bengal. It must be acknowledged that this table contains at least some evidence in favour of the views expressed.

TABLE XVII.

Poverty and Leprosy.

Prosperous Districts.	Ratio of lepers per 10,000 of population (1872).			Districts Improving in Prosperity.	Ratio of lepers per 10,000 of population (1872).			Poor Districts.	Ratio of lepers per 10,000 of population (1872).		
	Ratio of lepers per 10,000 of population (1872).	Ratio of lepers per 10,000 of population (1872).	Ratio of lepers per 10,000 of population (1872).		Ratio of lepers per 10,000 of population (1872).	Ratio of lepers per 10,000 of population (1872).	Ratio of lepers per 10,000 of population (1872).		Ratio of lepers per 10,000 of population (1872).	Ratio of lepers per 10,000 of population (1872).	Ratio of lepers per 10,000 of population (1872).
Backergunge.	1'1	2'5	1'4	Balasore.	7'5	13'7	12'0	Backoora.	29'9	37'1	36'3
Chittagong.	2'0	4'3	2'3	Bhagalpur.	3'1	5'0	4'5	Beerbhoom.	41'2	32'7	35'2
Dacca.	4'5	5'6	3'5	Cuttack.	2'5	11'2	8'6	Bardwan.	21'6	29'5	21'5
Darjeeling.	10'0	11'8	7'5	Farrukhore.	4'1	4'0	2'7	Chittagong Hill Tracts.	...	...	5'9
Dinapore.	3'3	7'4	4'6	Hazaribagh.	1	2'0	1'6	Gya.	9'8	5'3	7'5
Jalpaiguri.	4'5	12'0	9'9	Hoochly and Howrah.	6'0	9'5	5'4	Manbhoon.	5'4	12'3	1'3
Jessore.	3'4	4'0	3'9	Mymensingh.	7'4	8'4	6'3	Midnapore.	8'3	9'2	7'9
Madda.	5'2	7'2	6'0	Nuddea.	9'7	9'4	7'0	Monghyr.	2'0	5'4	5'4
Noakhully.	7	1'6	1'4	Sarun.	5'3	5'1	4'4	Meershedabad.	13'1	12'7	8'2
Singhbhoon.	3	4'7	3'5	Sonthal Pergunnah.	4'0	5'0	3'5	Patna.	7'1	7'6	3'9
Tipperah.	4'1	4'9	3'3	24 Pergunnahs.	4'0	5'1	3'4	Pooree.	3'3	13'6	15'5
								Palna.	4'2	6'4	4'1
								Rangpore.	10'7	14'0	6'8
								Shahabad.	5'0	8'2	4'4
								Tirhoot.	2'5	3'0	2'7

Before proceeding to the remainder of this chapter it may be well to summarise the results arrived at. Attention must again be drawn to the many difficulties encountered. These depend in the first instance on the vastness of India, and an imperfect knowledge of all such matters as the habits and customs of the people and their material condition. Secondly, the census figures are only of relative value where numerical questions, such as the specific leper population, are under consideration. For the general distribution and prevalence of the disease they convey sufficiently accurate information, but for the study of more special points in the ætiology of leprosy their value is perhaps not so great. At present only three sets of figures exist for India, and this is not sufficient to act as a safe check, especially as in a decennium many changes occur, capable of seriously affecting the ratios. To gauge the calculations and deductions based on them more efficiently returns should be made at frequent intervals—a matter of impossibility.

All that has been said on climate, cholera, and famine demonstrates clearly that great caution must be exercised in all arguments regarding the numerical diffusion of leprosy. Though all these statements cannot be taken as absolute, and are not free from doubt and above criticism, they at least show that, in any comparison of two areas, all the concomitant conditions which may influence the population at large must be carefully considered; and this has been only too often neglected by those who raised the outcry about the rapid increase of leprosy in India. It has not been the intention of the Commissioners to convey the idea that a severe famine invariably does act on the leper population in a particular manner, but that it may do so, and if the census figures be correct, in many instances seems to do so. Again a particular climate has not been considered the cause of a scanty leper population, but it has been claimed that a climate, combined with the telluric, geological, ethnological, and other conditions

of a district, may have a definite influence. Cholera has been used as a test of unhealthiness and bad hygiene, and it has been suggested that in a district, the permanent home of cholera, the surroundings may be such as to favour the diffusion of leprosy.

Still greater difficulties make themselves felt while discussing the relation between the material prosperity of the people and leprosy. The Commissioners incline greatly to the belief that the greater the poverty of a district, the more prone the latter is towards leprosy. Considering India as an unit the masses are poor and live in defective hygienic conditions, far below the level of the western European nations, and apparently have lived in such surroundings for centuries. An absolute comparison between the individual provinces and districts is impossible, but the Commissioners express their strong belief that it can be shown that the numerical diffusion of leprosy depends, among other factors, greatly on the well-being of the population, and that with the furtherance of prosperity, education, and hygiene, and in fact with a substitution of a standard of maintenance for that of subsistence, leprosy will materially decrease in India as it has done in Europe. Such progress has been going on actively in India for the last twenty years, and it is hoped that under the British Government the native standard of health and wealth will more and more approach that of the masses in the mother country.

Leprosy an Endemic Disease.

In a subsequent chapter it will be more fully explained that in leprosy, as in tuberculosis, a special individual disposition is necessary for the acquisition of the disease. Here an attempt has been made to show that it is by no means improbable that the general susceptibility to leprosy of a district and its inhabitants depends on certain conditions: in other words, there seem to be certain factors, partly connected with the climatic, economic, social, or hygienic conditions which establish the

endemic nature of this affection. A disease can only be endemic in an area where all the conditions leading to its acquisition exist. Leprosy is an infectious disease, but besides the *contagium vivum* a certain disposition of the individual is necessary to produce the disease in the latter. Therefore it can only be endemic in areas where besides the virus, those factors also exist which are held responsible for the special disposition in the individual.

This virus will probably be found in the resting stage of the bacillus lepræ, but as yet the living microbe has not been found outside the human body. Assuming that, since the disease is highly prevalent, this virus is widely distributed throughout space, and that special conditions of an area largely predispose its population, it is evident that every facility is offered for an acquisition of the disease *de novo*, that is, an acquisition of leprosy apart from contagion. Indeed if the virus is widely distributed, contagion may be practically neglected, since all measures directed against the latter could be of no avail in stamping out the disease. Tetanus, to give an example, is no doubt a contagious affection, the specific parasite, however, in some form or other is so widely distributed, that the risks of acquiring this disease through contact, direct or indirect, practically vanish when compared with the chances of an independent infection from the soil or dust, an individual thus acquiring the disease *de novo*.

It is not intended to imply by the term *de novo* that the parasite is of no ætiological importance, but that the microbe may reach the body and set up the disease quite apart from contagion if only the required disposition exists. At the present time it is an only too common practice to consider any disease, dependent on a specific organism, contagious under all conditions alike and without allowing degrees of contagiousness. The conditions under which a disease becomes contagious are often regarded as unimportant, and it is these which actually lead to the establishment of a predisposition.

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endemic nature of this affection. A disease can only be endemic in an area where all the conditions leading to its acquisition exist. Leprosy is an infectious disease, but besides the *contagium vivum* a certain disposition of the individual is necessary to produce the disease in the latter. Therefore it can only be endemic in areas where besides the virus, those factors also exist which are held responsible for the special disposition in the individual.

This virus will probably be found in the resting stage of the bacillus lepræ, but as yet the living microbe has not been found outside the human body. Assuming that, since the disease is highly prevalent, this virus is widely distributed throughout space, and that special conditions of an area largely predispose its population, it is evident that every facility is offered for an acquisition of the disease *de novo*, that is, an acquisition of leprosy apart from contagion. Indeed if the virus is widely distributed, contagion may be practically neglected, since all measures directed against the latter could be of no avail in stamping out the disease. Tetanus, to give an example, is no doubt a contagious affection, the specific parasite, however, in some form or other is so widely distributed, that the risks of acquiring this disease through contact, direct or indirect, practically vanish when compared with the chances of an independent infection from the soil or dust, an individual thus acquiring the disease *de novo*.

It is not intended to imply by the term *de novo* that the parasite is of no ætiological importance, but that the microbe may reach the body and set up the disease quite apart from contagion if only the required disposition exists. At the present time it is an only too common practice to consider any disease, dependent on a specific organism, contagious under all conditions alike and without allowing degrees of contagiousness. The conditions under which a disease becomes contagious are often regarded as unimportant, and it is these which actually lead to the establishment of a predisposition.

Modern bacteriological research has disclosed many facts which clearly indicate that contagiousness is an extremely relative term. This will be more fully considered subsequently, and here only a few points will be mentioned in proof of how easily general causes, such as poverty, famine, and precarious living may lead to a special disposition towards a disease—may, in fact, cause such disease to be endemic over a certain area. It has been shown that dogs of one colour are more susceptible to anthrax than those of another; pigeons and hens, normally resistant against the same disease, are easily infected, if allowed to starve. Again rabbits, naturally more or less refractory to quarter evil, lose their immunity through fatigue and over-exertion; and Hankin has shown that a meat diet increases the resistance of ordinary rats against anthrax, while a milk diet causes them to be susceptible to this disease. These few facts—and instances might easily be multiplied—show how readily a disease, originally non-contagious for a certain class of animals, may be rendered contagious. The virus has remained unchanged all the time, but an alteration in the organism of the individual has taken place.

An endemic area, then, would be one where (a) the virus in some form or other is present, and where also (b) such conditions exist as are calculated to exercise a special predisposing influence on the population, thus enabling the parasite not only to enter the body but also to grow and thrive in the same. It has been seen that there are districts in India where leprosy is exceedingly prevalent, and has been so at all three enumerations. These districts agree chiefly in the following points, *viz.*, the existence of poverty, insanitary conditions, over-population, unhealthy or moist climate. Whether the virus is also abundant in these districts cannot be proven, so long as bacteriology is almost ignorant regarding the life history of the leprosy bacillus. As the disease has existed in India since antiquity, it is highly probable that the bacilli in a resting stage are widely distributed, ready to encounter the susceptible

individual, and with the experience gained from the ætiology of tuberculosis, it is quite legitimate to assume so. It may be objected that the assumption of a dormant condition of the bacillus lepræ outside the human body is a mere hypothesis. This hypothesis, however, explains all the facts in the diffusion of leprosy, and is, in reality, also accepted by those who believe in the spread of the disease by means of contagion, when they attribute the acquisition of leprosy to such acts as the washing and wearing of lepers' clothes, and so forth. Again, there are similar cases in bacteriology, *e.g.*, tetanus, where the specific organisms no doubt exist in the soil or dust, in the form of spores, and yet have never been demonstrated microscopically.

At the present time no one denies the necessity of a special predisposition in the case of tuberculosis. "It is established beyond doubt that for the development of the latter disease there must exist a certain *ensemble* of unhygienic and bad or poor conditions of life, often perhaps transmitted from the parents and ancestors. Thus the importance of general, social, as well as hygienic, conditions is, *eo ipso*, acknowledged."²⁰

Leprosy is not more frequent in some parts, as Bankoora and Assam, because the people are more careless here in their intercourse with lepers, but because the conditions here are more favourable to the origin and spread of the disease, just as the greater prevalence of tuberculosis among the industrial classes, as compared with the agricultural population in England, is not accounted for by the assumption that the former expose themselves more recklessly to the risks of contagion. How much heredity and contagion contribute to the spread of leprosy will be discussed in Chapters IV and V.

The consideration of the fact that even in those districts where leprosy is extremely prevalent but little changes in the affected population have taken place during the last thirty

(*) Dina Sandberg, *Zeitschrift für Hygiene* X, page 376.



years points rather to the existence of general conditions leading to a specific disposition. For there is no evidence to justify the assumption that the native is more careful in his intercourse with lepers now than he was a generation ago. Yet the disease remains stationary: indeed probably is slightly on the decrease. It is asked, "What is this due to?" A comparison with what has happened in England in the case of tuberculosis will most readily appeal to those less familiar with leprosy.

According to English statistics²¹ there has been since 1858 a steady decrease in the mortality from phthisis both in the agricultural and industrial population, and this decrease has taken place much more rapidly than the decrease of mortality from all causes during the same period. Again the decrease of mortality from phthisis in the industrial population has been proportionately greater than that in the agricultural classes. From these facts this follows, that the decrease in the general mortality establishes that a gradual improvement in the vital condition in England has taken place, and that this improvement accounts for the still greater decrease in the phthisis mortality. As Dr. Sandberg²² writes: "The steady decrease of the phthisis mortality in England argues strongly for a general development of sound hygienic principles throughout the various classes of the population and for the benefit arising from sound hygienic measures."

In England, then, the conditions leading to a general or individual disposition have been, and are, constantly counteracted, with the result that phthisis is on the decline. Now if the decrease in the leper population according to census statistics is an actual one, does it not seem more reasonable to assume that this is due to the improvement in social and hygienic conditions which undoubtedly has taken place during

⁽²¹⁾ W. Farr: Vital Statistics, 1885, pages 267, 268. Fr. Oesterlen: Handbuecher med. Statistik, pages 405, 406.

²² Loc. cit.

the last quarter of a century? If such decrease, however, be not accepted, may it not be expected that by means of such improvement the leper population, instead of remaining stationary, will gradually diminish? It must be the chief aim of the reformer to counteract the agents which are responsible for the fact that leprosy is endemic in India. It is impossible to attack the virus itself, but it seems not only possible to battle against the predisposing causes, but to do so with fair hope of eventual success. There is in India a tendency towards a decrease of the disease, and this is assuredly due to the rapid progress of the social, economic, and hygienic conditions all over the empire. With a further and continued improvement of these, it may be hoped that in India leprosy will cease to be an endemic disease.

Density of Population in Relation to the Diffusion of Leprosy.

The health and wealth of a population is closely connected with the density of the population, and for any other country it might fairly be assumed that the masses would always crowd to the richest areas. However, when it is remembered that the Indian ideas of the standard of life and comfort are very low, and that the people aim simply at subsistence in contradistinction to maintenance, it is necessary to exercise great care in forming an opinion as to the wealth and well-being of the population. The fixity of occupation and of condition, the great rigidity of domestic relations, necessitate a keen indisposition in man to disperse, and thus in some parts of the country there is no organised emigration as yet, while in other parts the people have gradually accustomed themselves to abandon their homes. A local congestion is thus easily established, all the more as the requirements of the masses are so moderate and the desire to increase them so weak. Now as a population tends to increase faster within a fixed area than the land yields food for it, and as according to

the principle of diminished return from land after the soil has been worked to a certain extent, the application to it of additional labour or capital ceases to bring in the same proportionate return as it did at first, and this decrease in productiveness is continuous, it is clear that the density of population is no index of the wealth of a district, and that the comparative wealth of the various areas must be estimated in a different manner.³³

Yet it seems proper to enquire into the relation between the leper diffusion and the density of population. The appended table shows clearly that no law exists between the two, whether famine districts be excluded or not. Bengal, Bombay, Madras, and the Punjab have been chosen, and these four provinces may suffice. Examples demonstrating the truth of the above statement might easily be multiplied.

TABLE XVIII.

Density of Population and Leprosy.

[Census 1881.]

DISTRICT.	No. of persons per square mile.	Lepers per 10,000 of population.	REMARKS.
BENGAL.			
Burdwan	516.66	29.5	
Bankura	397.46	37.2	
Beerbhoom	452.10	32.7	
Midnapore	495.44	9.2	
Hooghly	828.10	11.1	
Howrah	1,334.83	5.6	
TOTAL BURDWAN DIVISION	533.67	19.5	

(³³) J. A. Baines: Operations and Results in the Presidency of Bombay, Chapter II.

Table XVIII—continued.

Density of Population and Leprosy.

[Census 1881.]

DISTRICT.	No. of persons per square mile.	Lepers per 10,000 of population.	REMARKS.
BENGAL—continued.			
24-Pergunnahs	571.78	5.1	
Suburbs	10,932.13	6.0	
Calcutta	54,152.37	5.4	
Nuddea	592.79	9.4	
Jessore	692.99	4.0	
Khoolna	519.96	2.7	
Moorshedabad	572.20	12.7	
TOTAL FOR PRESIDENCY DIVISION	682.09	6.8	
Dinagepore	367.74	7.4	
Rajshahye	566.98	4.6	
Rungpore	601.83	14.9	
Bogra	490.23	6.7	
Pubna	710.19	6.4	
Darjeeling	125.75	11.8	
Jalpaiguri	201.65	12.9	
TOTAL FOR RAJSHAHYE DIVISION	443.76	9.2	
Dacca	756.65	5.6	
Furreedpore	719.78	4.0	
Backergunge	520.93	2.5	
Mymensingh	485.44	8.4	
TOTAL FOR DACCA DIVISION	580.06	5.6	

Table XVIII—continued.

Density of Population and Leprosy.

[Census 1881.]

DISTRICT.	No. of persons per square mile.	Lepers per 10,000 of population.	REMARKS.
<i>BENGAL—continued.</i>			
Chittagong	441.11	4.3	
Noakholly	500.17	2.6	
Tipperah	609.93	4.9	
Chittagong Hill Tracts	18.75	...	
TOTAL FOR CHITTAGONG DIVISION	294.94	4.2	
TOTAL FOR BENGAL PROPER	505.57	9.4	
<i>BOMBAY.</i>			
Ahmedabad	224.10	.8	
Kaira	500.	2.4	
Panch Mahals	158.38	2.7	
Broach	225.	2.5	
Surat	369.55	6.2	
TOTAL FOR GUJARAT DIVISION	281.3	2.8	
Thana	214.12	2.2	
Kolaba	255.11	11.3	
Ratnagiri	254.22	9.3	
TOTAL FOR KONKAN DIVISION	236.7	9.2	
Khandesh	124.41	14.1	
Nasik	131.51	7.5	
Ahmednagar	112.69	10.1	
Poona	168.40	12.0	
Sholapur	128.84	6.8	
Satara	212.98	11.0	
TOTAL FOR DECCAN DIVISION	144.1	10.8	

Table XVIII—continued.

Density of Population and Leprosy.

[Census 1881.]

DISTRICT.	No. of persons per square mile.	Lepers per 10,000 of population.	REMARKS.
<i>BOMBAY—concluded.</i>			
Belgaum	185.53	3.3	
Dharwar	194.68	1.8	
Kaladgi	110.90	2.9	
Kanara	107.85	1.2	
TOTAL FOR WESTERN KARNATIC DIVISION	148.8	2.4	
Kurrachee	33.9	1.8	
Hyderabad	83.3	1.2	
Shikarpur	85.2	.8	
Thar and Parkar	15.9	.5	
Upper Sind Frontier	58.0	1.3	
TOTAL FOR SIND DIVISION	50.3	1.1	
City and Island of Bombay	33,662	5.5	
TOTAL PRESIDENCY	*132.6	6.1	* Or excluding Sind and Bombay Island, 174.1.
<i>MADRAS.</i>			
Ganjam	484	4.0	
Vizagapatam	515	4.7	
Godavari	273	5.8	
Kistna	183	4.0	
Nelbore	140	3.2	
Cuddapah	128	1.8	
Kurnool	91	3.4	
Bellary	121	2.6	
Chingleput	345	10.0	
North Arcot	251	6.3	

REPORT OF THE LEPROSY COMMISSION:

On the other hand, the admissions on account of leprosy from the Native Army during the period of ten years, from 1879-1888 amounted to two hundred and twenty-nine, as will be seen from the subjoined table:—

NATIVE ARMY.

Admissions for Leprosy.

YEAR.	No. admitted.	REMARKS.
1879	34	
1880	35	1 death.
1881	25	
1882	25	
1883	20	
1884	18	
1885	8	
1886	19	2 deaths.
1887	20	
1888	25	
TOTAL	229	3 deaths.

It is impossible from a comparison of the two armies to deduce a racial predisposition, as the conditions under which the British soldier lives are entirely different from those of the native. The former is exceedingly well looked after and cared for, and resides for a limited number of years only in the country, while the native passes perhaps a lifetime in an endemic

Distribution of Leprosy.

area, and his mode of living does not in the least change after he enlists. In contrasting statistics, great caution must be exercised as to equality of the concomitant variations, a difficulty which has confronted the Commissioners over the length and breadth of this chapter.

There are in India no favoured races which are exempt from the disease, and it can only be want of experience which prompted one observer to remark: "I have never seen or heard of a case of leprosy in a pure European."³⁸ And it seems assuming too much that the fact of an Eurasian suffering should be explained as an inheritance through the native stock.³⁹

It is difficult to estimate to what extent the various races suffer. Arguing from general impressions, as accurate statistics are not obtainable, it would appear that the native element is undoubtedly more prone to the disease, and the unmixed European least; but accurate figures cannot be given. The difference, however, may well depend on the inequality of social rather than racial conditions, the native ranking lowest in such a scale, while the Eurasian occupies an intermediate level. The Commissioners are therefore of opinion that, *per se*, no one race is more liable to contract leprosy, and that given equal and favourable conditions, all will be affected alike. These few words must suffice on this subject.

Leprosy in Relation to Religion and Caste.

I.—Examined by religion the Kabirpanthis show the highest proportion for 1881. The Buddhists show very high leper ratios throughout, the Aborigines, on the other hand, low ones. The proportion for each religion is best stated in tabular form.

(³⁸) A Medical Report upon the Character and Progress of Leprosy. Royal College of Physicians, page 118.

(³⁹) C. N. Macnamara. Leprosy: A Communicable Disease. London, 1889, page 20.

Table XVIII—continued.

Density of Population and Leprosy.

[Census 1881.]

DISTRICT.	No. of persons per square mile.	Lepers per 10,000 of population.	REMARKS.
MADRAS—continued.			
South Arcot	372	6.6	
Tanjore	583	5.0	
Trichinopoly	341	4.0	
Madura	258	3.7	
Tinnevely	315	4.7	
Salem	209	2.2	
Coimbatore	211	1.4	
Nilgiris	95	6.3	
Malabar	410	5.1	
South Canara	246	9.4	
Madras City	15,031	10.7	
TOTAL FOR THE BRITISH DISTRICTS OF MADRAS	249	4.7	
Pudukota Territory	274	2.8	
TOTAL FOR THE PRESIDENCY, INCLUDING PUDUKOTA TERRITORY	250	4.6	

[Census 1891.]

PUNJAB.			
Jullundur*	633.34	2.3	* An asterisk denotes a district with an Asylum.
Amritsar*	625.04	1.5	
Sialkot*	562.45	1.4	
Gurdaspur	499.69	1.7	
Delhi	495.10	1.2	
Hoshiarpur	450.82	3.2	
Ludhiana	446.47	1.8	
Simla*	437.66	28.8	

Table XVIII—continued.

Density of Population and Leprosy.

[Census 1891.]

DISTRICT.	No. of persons per square mile.	Lepers per 10,000 of population.	REMARKS.
PUNJAB—continued.			
Umballa*	375.24	3.2	* An asterisk denotes a district with an Asylum.
Gujrat	370.97	2.5	
Gurgaon	337.16	2.6	
Rohtak	328.53	1.1	
Lahore	292.38	.4	
Peshawar	287.95	.8	
Karnal	280.21	1.3	
Gujranwala	228.76	.5	
Ferozepore	206.10	1.5	
Rawaipindi*	183.15	3.6	
Hazara	172.61	3.0	
Jhelum	152.45	2.3	
Hissar	150.30	1.7	
Muzaffargarh	111.36	1.1	
Mooltan	103.87	.4	
Shahpur	101.98	.7	
Bannu	96.77	.8	
Montgomery	86.81	.6	
Kangra*	79.69	10.8	
Jhang	74.40	.5	
Kohat	73.32	.6	
Dera Ghazi Khan	72.07	.7	
Dera Ismail Khan	51.59	.3	
TOTAL FOR THE PUNJAB	188.55	2.0	

To gain an idea of the relative population of the areas in question it may be well to mention the specific population of

more familiar countries. Thus, for Belgium, according to an enumeration made in 1879, it was four hundred and eighty-six per square mile, for England and Wales in 1881 as much as four hundred and forty-five, while for Norway and Sweden it was as small as fourteen and twenty-six, respectively, for the censuses of 1877 and 1878. If a proof be required to show the truth of the statement that a relation between wealth and density of population is not a matter of necessity, this will best be found in Sind. Being near the frontier, with a good sea-port, it has for a long time been the resort of traders from the north and west. In the interior are one or two large trade centres rapidly increasing under the influence of established lines of railway. Prosperity has grown under good harvests and improved means of transport to market. Altogether Sind must be considered as being greatly above the average as regards its wealth, and yet it is but scantily populated.³⁴

Predisposition of Races.

"The people of India proper, by which term is meant the whole of the Western Peninsula and the plains west of the Brahmaputra consist of a number of races and tribes of most diverse origin, and owing to the restrictions of caste which rigorously prohibit intermarriage, they have not amalgamated to form a nation or even a number of nations as, for instance, Celts, Saxons, Danes, and Normans have done to form the English and Scotch of to-day. Religious and sectarian differences have added to the original differences of race, so that at the present day as well as throughout her whole past history, while India has always been a collection of many countries, no one of these constitutes or has ever constituted a nation in the European sense of the term."³⁵ "The population of India proper consists of the dark aboriginal races, descended from the original occupants of the country at the time of the first Aryan invasion; (2) the fair or at least lighter-tinted descendants of

⁽³⁴⁾ J. A. Baines. Op. cit., Chapter II.

⁽³⁵⁾ H. E. Blandford. Op. cit., page 36.

the Aryan and Scythian immigrants, who entered India from the north-west; (3) mixtures of the two in all degrees of proportion; (4) immigrants from the coasts, such as Parsis, Jews, Arabs, and lastly the English, and other Europeans; and (5) Eurasians, the mixed descendants of Europeans and other races."³⁶ "The population of Burma is more uniform; it includes several distinct tribes, but the great majority of these are of the same or nearly allied races, and the absence of caste distinction allows of their amalgamation to a greater extent than in India, at least in those parts of the country that are settled and civilised."³⁷

Now leprosy affects all these ethnic elements, though severally to a different degree. It does not spare the European of unmixed blood, and the Commissioners during their personal enquiries met with five cases representing three nationalities, German, French, and English. Eurasians suffering from leprosy are frequently found. These facts, however, are so well-known that it is hardly necessary to delay any further over them. It may be interesting to mention that since 1860 from the European army (Bengal, 1860-69, and India, 1870-89), two soldiers have been invalided on account of leprosy, one from the Bombay Army in 1879, and the other from the Madras Army in 1887; and two have been admitted for the same cause. For the following details the Commissioners are indebted to the Statistical Medical Officer with the Government of India:—

EUROPEAN ARMY.

(Bengal, 1860-69 and India, 1870-89).

Total invalided	55,853
Invalided for—	
Venereal diseases	2,829
Phthisis	3,963
Leprosy	2
Admissions for leprosy	2

1 in Bengal Army in 1877.

1 in Madras Army in 1886.

⁽³⁶⁾ H. E. Blandford. Op. cit., page 35

⁽³⁷⁾ Ibidem, page 36.

TABLE XIX.

Proportion per each Religion on Ten Thousand.

[Census 1881.]

RELIGION.	Lepers per 10,000 of same religion.	Ratio of followers of same religion per 10,000 of entire Indian population.	REMARKS.
Kabirpanthis .	7.7	14	
Buddhists .	7.0	135	
Nat worshippers	6.0	6	
Hindus .	6.0	7,402	
Christians .	5.6	73	
Muhammadans .	5.0	1,974	
Satnamis .	4.3	16	
Parsis .	3.9	3	
Aboriginals .	3.3	253	
Jains .	2.2	48	
Sikhs .	1.9	73	

"Under 'Aboriginals' those have been grouped together who, not having been converted to Christianity or to Islam or the Hindu belief, retain, if they have any religion at all, the primitive cult of their forefathers, adoring nature under the various forms or images they have chosen to select as representative of Deity. There can be no doubt that in such an estimation errors have occurred when the difficulty of definition and elasticity of the designation 'Hindu' is considered, but the main inaccuracy resulting from mistakes will probably be found in an under-estimate of the Aboriginals and Jains, many of the latter being returned as Hindus."⁽¹⁾

For such general matters as are discussed in this chapter such deficiencies are of little importance. Table XIX conveys the fact that leprosy does not spare any religion. The Bud-

(¹) Imperial Census Report for 1881, pages 17 and 23.

dhists are found chiefly in Burma, nine-tenths of this population being followers of Gautama, while there are not two hundred thousand to be found over the length and breadth of the continent of India. The Nats are entirely restricted to Burma. The Jains exist in numbers in the presidency of Bombay and in Rajputana only, the North-Western Provinces coming next in order. Their scruples respecting the destruction of animal life or touching animal food are well known, and this is important with regard to a theory of the origin of leprosy which is based on the consumption of fish. The Jain community is greatly commercial in character, and as a rule in easy circumstances, and in some districts, at Gujarat and Ahmedabad, with considerable or predominant influence. This may to a great extent account for the small amount of leprosy found amongst them.

"The Satnamis, who include a large number of agricultural Chamars within their body, are found almost exclusively in Raipur and Bilaspur. The true Satnamis abstain from tobacco, intoxicating liquors and drugs, animal food, and from certain vegetables. They are of taller physique, fairer and better made than the other inhabitants of the country. Their food consists of the produce of the fields, of which they always have plenty, the virgin soil yielding a copious outturn for comparatively little labour. Their abstinence from animal food (which in a country so hot as Chhattisgarh works more harm than good), and from all sorts of intoxicating drinks and drugs, and their agricultural pursuits give them health. Their ideas of cleanliness are capable of much improvement; they sleep in a hovel without windows, with an array of children of all ages around them, squatting on the floor, on which the veriest apology for a coarse mattress is sometimes spread."⁽²⁾

The Kabirpanthis, amongst whom relatively the largest number of lepers is found, are also chiefly recorded in the

(¹) Imperial Census Report for 1881, page 42.

(²) Ibidem, pages 43 and 45.

Central Provinces, though they undoubtedly exist also in other parts of India, as Benares, Bengal, and as far as the Deccan. They do not touch any spirituous liquors or flesh. In their social relations, habits, and superstition they differ but slightly from the Satnamis.⁽⁴³⁾

The Sikhs, who have less lepers in their ranks than any other religious body, are found mainly in the Punjab, the only instance in which they appear in any strength outside the Punjab being in the adjacent province of Sind. But they are met with scattered about in small groups all over Hindustan and in some parts of the Deccan. Although composed of different ethnic elements they form a race with as marked features as any other in the Peninsula.⁽⁴⁴⁾ They have preserved their ancient talent for war, and they supply a contingent of picked men to the Anglo-Indian army. They are altogether perhaps the manliest and finest set of men in the empire. Tobacco smoking is strictly prohibited, but they do not abstain from spirituous liquors and animal food, the flesh of the cow only being a forbidden dish.

These few remarks may suffice. The Sikhs and Jaips are undoubtedly most exempt from leprosy, and the Parsis approach them closely in this respect. These three bodies are more or less select, the Sikhs representing the physically finest class of men, while the Jains and Parsis stand commercially highest, and belong to the wealthier portion of the community. The healthy life of the Satnamis has been alluded to. Excluding the Aborigines, leprosy is least found in these four sections, and this may perhaps be explained by their social or physical superiority. That, however, an abstinence from animal food by no means prevents a diffusion of leprosy is well illustrated by the Kabirpanthis. Among the Buddhists and Nats much leprosy is found, but it is well known that the social and personal conditions of the Burmans are low, and in many parts

(⁴³) Imperial Census Report for 1881, pages 45 to 48.

(⁴⁴) Barth: The Religions of India.

deplorable. Table XIX thus seems to imply that where the religious belief is coupled with bad social conditions the leper ratios are highest, while, when favoured by exceptional surroundings, the proportion decreases considerably. Intermediate are the Hindus, Christians, and Muhammadans, and these may be said to represent the average population of India as regards personal and hygienic conditions.

II.—At the recent enumeration the lepers were arranged according to caste, since a classification based on the various forms of religious belief becomes more and more uncertain, as time and enlightenment advance, and is thus open to criticism. Drs. Lewis and Cunningham, as far as opportunities were offered, enquired into the relation of caste to leprosy. Their investigation, however, was confined to Kumaun only. They write in their report as follows: "As the inhabitants of Kumaun virtually consist of two classes only—Rajputs and Domes, the former representing an Aryan population, the latter the Aboriginal people, whilst other classes are only very sparingly represented—the evidence, such as it is, is in favour of impartial distribution of the disease."

The Commissioners can assert with confidence, from personal experience and enquiry, that no caste is exempt. It remains only to examine to what degree the various classes are affected, and whether one or other body is relatively more liable to suffer from leprosy.

Unfortunately it was impossible to obtain statements of the lepers arranged according to castes from the various provinces or presidencies. Accurate details could be obtained from the Punjab only, and the following remarks therefore apply exclusively to this province. As far as general impressions go, however, the conclusion derived from the statistical evidence of the Punjab leper population may be taken to represent the state of affairs in India generally.

In the following table the lepers have been arranged according to castes, the latter being again subdivided as to their

material prosperity into three classes, *viz.*, rich, moderately prosperous and poor. A classification of this nature no doubt involves great difficulties and cannot be altogether without inaccuracies. It has, however, been prepared as carefully as possible after due consultation with British officials and educated natives most versed in this matter. No European, and perhaps even no Indian, possesses a perfect knowledge of the caste systems, and hence the following remarks must be accepted as suggestions merely.

From the following statistics it appears that the least amount of leprosy is found among the wealthy or rich castes, the ratio being less than one per ten thousand, while the disease is most prevalent among the poorer castes (3.05 per ten thousand). This suggests the fact that leprosy like tuberculosis has a certain predilection for people living under bad and more or less miserable conditions. It is greatly to be regretted that on account of the unavoidable want of statistical data at the time of writing, statements regarding other parts of India were unobtainable, because the evidence afforded by one province can hardly be considered sufficient, when a question of so difficult a nature is under discussion. In future, however, the degree to which the richer and poorer castes respectively are liable to suffer from leprosy should demand attention. It has already been shown that the poverty-stricken districts present higher ratios than the wealthier ones, and if the distribution of leprosy among the different castes should also establish this connexion between the disease and bad social or hygienic conditions, the importance of an individual predisposition is placed beyond a doubt. The further investigation of this matter must, however, be left to others who are more familiar with Indian social matters and who are in possession of all the statistical evidence obtainable. The few facts at the disposal of the Commission clearly point to the influence of poverty and its accompaniments or consequences on the distribution of leprosy.

TABLE XX.

Abstract showing Lepers by Castes for the Punjab.

[Census 1891.]

Class.	CASTES.	Total of caste.	Number of lepers in caste.	Proportion per 10,000.	REMARKS.
I.—Rich.	Arora . . .	667,197	33		The Feudatory States are included in the totals.
	Bania . . .	442,495	43		
	Bhabra . . .	18,137	1		
	Bohra . . .	3,433	1		
	Kaith . . .	13,598	3		
	Kalal . . .	48,913	10		
	Khatra . . .	447,933	48		
	Khoja . . .	95,887	3		
	Mahajan (Pahar)	20,700	2		
	Parsi . . .	526	1		
	Sud . . .	21,804	5		
	Total Class I.	1,780,623	150	.84	
II.—Moderately wealthy.	Arain . . .	896,314	161		
	Awán . . .	608,051	92		
	Baghdán . . .	18,537	2		
	Bishnoi . . .	8,213	2		
	Brahman . . .	1,111,838	439		
	Muhial . . .	10,871	1		
	Daudpotra . . .	19,269	1		
	Dhund . . .	48,415	32		
	Dogar . . .	69,712	15		
	Gakkhar . . .	28,771	19		
	Ghirath . . .	170,348	192		
	Gujar . . .	711,800	195		

Table XX—continued.

Abstract showing Lepers by Castes for the Punjab.

[Census 1891.]

Class.	CASTES.	Total of caste.	Number of lepers in caste.	Proportion per 10,000.	REMARKS.
II.—Moderately wealthy— <i>contd.</i>	Ját . . .	4,631,283	715		
	Kamboh . . .	151,160	16		
	Khattar . . .	9,773	2		
	Khokhar . . .	139,964	14		
	Mughal . . .	130,760	37		
	Pathan . . .	970,466	126		
	Pujári . . .	3,004	9		
	Rájput . . .	1,790,359	462		
	Rathi . . .	100,929	245		
	Ror . . .	43,212	10		
	Saini . . .	125,352	22		
	Shekh . . .	366,973	87		
	Sunár . . .	176,400	26		
	Tarkhán . . .	664,260	103		
	Thakkar . . .	27,180	28		
	Ulmá . . .	43,086	4		
	Total Class II	13,076,300	3,057	23	
III.—Poor.	Aheri . . .	16,552	2		
	Ahir . . .	197,649	26		
	Barwálá . . .	63,847	18		
	Batwál . . .	23,488	7		
	Bawariá . . .	26,431	9		
	Bazigar . . .	17,174	2		
	Bhará . . .	67,537	11		
	Bharbunjá . . .	8,105	3		

Table XX—continued.

Abstract showing Lepers by Castes for the Punjab.

[Census 1891.]

Class.	CASTES.	Total of caste.	Number of lepers in caste.	Proportion per 10,000.	REMARKS.
III.—Poor— <i>contd.</i>	Bhat . . .	38,098	37		
	Bhatiárá . . .	18,707	6		
	Biloch . . .	416,802	29		
	Chamár . . .	1,188,018	334		
	Changar . . .	36,391	2		
	Cihimbá . . .	144,835	21		
	Chuhrá . . .	1,224,967	109		
	Dabgar . . .	794	1		
	Dagi and Koli . . .	169,767	291		
	Daolí . . .	2,289	2		
	Darzi . . .	39,530	9		
	Dhanak . . .	73,562	9		
	Dhangrí . . .	2,199	2		
	Dhobí . . .	158,876	19		
	Dumná . . .	68,971	137		
	Faqír . . .	313,201	81		
	Gadaria . . .	23,354	11		
	Gaddi . . .	22,861	62		
	Gagra . . .	1,862	1		
	Garri . . .	1,619	1		
	Ghosi . . .	3,278	2		
	Hadni . . .	4,177	2		
	Hazara . . .	226	1		
	Hesi . . .	6,308	8		
	Hijrá . . .	631	1		
	Jaiswará . . .	6,809	1		
	Jhinwar . . .	473,094	113		

Table XX—continued.

Abstract showing Lepers by Castes for the Punjab.

[Census 1891.]

Class.	CASTES.	Total of caste.	Number of lepers in caste.	Proportion per 10,000.	REMARKS.
III.—Poor —contd.	Jogi and Rawal .	91,937	31		
	Julaha .	670,345	161		
	Kanet .	368,359	673		
	Kanjar .	3,138	4		
	Kashmiri .	225,307	52		
	Khanzadā .	3,471	1		
	Kharral .	52,029	3		
	Khatik .	17,446	5		
	Kori .	12,010	2		
	Kumhar .	540,759	116		
	Kunjra .	6,481	1		
	Kurmi .	1,897	2		
	Labana .	56,154	9		
	Lilari .	27,597	6		
	Lohar .	352,780	89		
	Machhi .	201,307	22		
	Mahtam .	56,984	3		
	Mali .	201,189	39		
	Mallah .	93,858	15		
	Maniar .	12,787	5		
	Megh .	50,201	2		
	Meo .	120,578	29		
	Mirasi .	245,214	62		
	Mochi .	407,634	59		
	Nai .	383,017	97		
	Naik .	701	1		
	Nat .	9,963	3		

Table XX—concluded.

Abstract showing Lepers by Castes for the Punjab.

[Census 1891.]

Class.	CASTES.	Total of caste.	Number of lepers in caste.	Proportion per 10,000.	REMARKS.
III.—Poor —concl.	Native Christians	19,176	28		
	Nungar .	18,919	4		
	Od .	23,670	3		
	Penja .	15,489	1		
	Qassab .	120,799	16		
	Rahbari .	3,768	1		
	Raj .	12,527	3		
	Rangrez .	16,265	1		
	Rawat .	18,437	3		
	Rehar .	1,095	10		
	Saiad .	289,449	52		
	Sansi .	23,647	1		
	Sarerā .	11,475	8		
	Tamboli .	817	1		
	Tanaoli .	58,027	8		
	Teli .	308,955	53		
	Thathera .	5,021	2		
	Thori .	8,207	2		
	Thavi .	3,230	3		
	Turk .	6,191	2		
Total Class III		10,040,316	3,064	3'05	
I.—Rich castes		1,780,623	150	84	
II.—Moderately wealthy castes.		13,076,300	3,057	2'3	
III.—Poor castes		10,040,316	3,064	3'05	

Asylums and the Distribution of Leprosy.

I.—There being no segregation in India, it may be asked whether on the hypothesis of contagion the practice of collecting lepers at one centre might not become a source of danger to the community. In all the Asylums of the Punjab the lepers are allowed, on special days at least, to go out into the bazaars and the neighbourhood to procure food or whatever they require, thus mixing freely among the people. If by this means the disease were liable to be spread amongst the population, an increase should be noticeable in the leper ratios of each district from one census to another, all the more as the number of inmates is steadily increasing from year to year. Such increase, however, cannot be traced, as the following table will show:—

TABLE XXI.

Asylums and the Spread of Leprosy.

ASYLUM AND DISTRICT.	Ratio per 10,000 (1st Census).	Ratio per 10,000 (2nd Census).	Ratio per 10,000 (3rd Census).	REMARKS.
Amritsar . . .	6.3	4.4	1.5	The ratios are calculated on 10,000 of the population.
Jullundur . . .	6.5	3.0	2.3	
Kangra . . .	18.0	14.5	10.8	
Rawalpindi . . .	10.4	5.0	3.6	
Sialkot . . .	6.4	3.8	1.4	
Simla . . .	34.7	28.6	28.8	
Umballa . . .	9.1	4.9	3.2	

It will not be necessary to delay any further over this matter as the above statistical details are sufficient evidence against the assumption of the spread of leprosy around an Asylum as a possible centre of infection. The three censuses point clearly to a decrease of leprosy in the respective districts,

and this can in no way be due to segregation, as such is by no means enforced in any of the Institutions mentioned in the table. The same applies to all other Asylums, but it is not necessary to devote more time or space to this matter.

II.—Again the increase in the number of inmates of an Asylum has been used as an argument that leprosy is rapidly spreading in India. Alarmists especially make use of the returns of Asylums and dispensaries to prove an increase of the disease. Such arguments are illogical and incapable of showing what they are intended to do. Dispensaries and hospitals alike were unpopular in India but a short time ago, and the Asylum to the leper especially distasteful. By gradual and slow education they came to understand the blessing of such philanthropic Institutions and learned to seek an abode in them. All therefore that can be deduced from such figures is an increased popularity of such homes. But it is not legitimate to draw deductions from hospital returns as to the increase or decrease of leprosy. In all such matters the education of the people is of great importance. It might, to take a more familiar example, be thought that adenoid vegetations of the nasopharynx were becoming commoner in England, because patients recognise the advantages of treatment more fully now and appear oftener at the hospitals to be operated on, while formerly they simply neglected their condition. These growths have always been common in England, but the affected did not seek relief. So it is with leprosy, and it may be hoped that the people in India will be still further educated to recognise the advantages of Asylums and palliative treatment. It is well known to all Civil Surgeons that the native has an abhorrence of a ward and does not seek admission into a hospital for chronic diseases, though he has great faith in practical surgery, and its more obvious and striking successes. This form of argument from dispensary and asylum returns is, however, reduced to an absurdity when the Matoonga Asylum at Bombay is quoted to establish the increase of the leprosy

population in India.⁴⁵ For into this Asylum all the lepers of Bombay and its neighbourhood, as far as room could be provided for them, were crowded and retained under a Municipal Act, and admission at the inauguration of the Institution, at least, could by no means be considered voluntary. Nor was there an option given to the inmates to leave the Asylum at will. In fact, the whole management of lepers in Bombay being placed under the Municipal authorities, a police guard was stationed at the entrance of the Asylum at the time of the visit by the Commission. That the procedure was for the good of the lepers who lived in clean and comfortable quarters, tended by a skilled physician, there can be no doubt, but to say "that many applicants were refused admission and that this is a proof of the great number of lepers, or of the increase of the pest in India," challenges open criticism.

III.—The presence of an Asylum in a district often attracts numbers of lepers from neighbouring regions, and this is a point which must not be left out of sight when an enquiry is made into the leper density of a district. This applies especially to such localities as border on native or feudatory States, for in such cases immigration is not at all uncommon. The lepers finding more congenial conditions under the British rule leave their own State. Moreover, it has been pointed out in the Census Reports, that such migration of people of all classes from native into British territory is by no means uncommon—a silent testimony to the excellence of the European government.

In Kumaun the percentage of lepers is very high, and it was found by Drs. Lewis and Cunningham⁴⁶ that the portions of the district which are specially affected, are near the Nepal frontier, and there is no doubt that many of the unfortunate people cross the border to find more favourable surroundings.

⁽⁴⁵⁾ Leprosy and Vaccination, by W. Tebb.

⁽⁴⁶⁾ Op. cit.

That they should gravitate around Almora with its excellent Asylum is not surprising. Again the leper ratios for the Simla district are very high. Simla lies embedded amongst feudatory States, and has an old established Asylum at Subathu. The total number of lepers registered in the Census Reports for this district is only a little above the actual number of inmates at the Subathu Asylum. From information, kindly supplied by Dr. Carleton, it was gathered that a large number of the patients admitted come from Garhwal, but the largest number migrate from Kangra, and many seek admission from the native States. It is evident, therefore, that the ratios for Simla, given in the three censuses (34.7, 28.6, and 28.8, respectively), by no means represent the actual amount of leprosy for the district. It was found that of forty-seven patients at the Rawalpindi Asylum fifteen belonged to Kashmir or Punch and two to Afghanistan, while at Sialkot, of forty lepers, thirteen had obtained admission from distant districts, and of these, four from Jummoo and Patiala. "At the Dehra Dun Asylum," Dr. G. B. Rutledge writes, "of one hundred inmates only twelve belonged to the district itself, eighty-two having sought admission from native States, and six from neighbouring districts." The same is true of other frontier Asylums, and there can be no doubt that a constant flow from outlying districts, and especially from native States, takes place. These points are especially worthy of consideration with regard to the hill tracts. Though undoubtedly leprosy prevails greatly in these regions, the ratios in many instances are increased by immigration. Whenever, therefore, a district shows a dense leper population, one of the points of enquiry must be, whether an Asylum exists in the locality, and how many of the inmates of such Asylum have immigrated from outlying regions.

Leprosy and Vaccination.

It has been maintained that "the synchronicity between the spread of leprosy and the extension of vaccination has

given rise, in some districts, to such a dread of vaccination that every device is resorted to by thoughtful parents to prevent their children from being vaccinated."⁴⁷ The history of leprosy of India by no means bears out the assertion that such "spread or recrudescence of the disease has taken place during the last thirty years." It will be shown in the following lines that, apart from the fact that the above dictum regarding "the connexion between the extension of the State-provided remedy against small-pox and leprosy" involves a serious *petitio principii*, a dread of infection through vaccination does by no means exist in India, and no uneasy feeling is exhibited on this account and also that there is no reason to fear a spread of this pest by such means.

It is true that in certain localities hostility to the operation is met with, but this is due chiefly to the inherent suspicion of an uneducated and ignorant people of any proceeding of which the reason is not understood, and also among Hindus to *quasi*-religious motives. Were this hostility to the operation based upon observance of its confirmed results in spreading leprosy or other diseases, the opposition should have come at some time subsequent to the introduction of the practice. As a matter of fact, however, it is only at first that this is observed, and as time wears on, vaccination becomes more and more readily accepted by the people. In not a single instance did a leper accuse vaccination as the cause of his misfortune, although the Commissioners enquired in every case into the theory a patient might offer for the development of his disease. As enlightenment and education advance, the native becomes more and more awake to the benefit conferred on him and his children by vaccination. Such statements as those quoted above can only delay the progress of the work inaugurated by a philanthropic prince by calling up groundless fears and anxieties in the mind of an uneducated people.

⁽⁴⁷⁾ W. Tebb, *Leprosy and Vaccination*, page 13.

This whole question deserves fuller consideration. Since vaccination is said to diffuse leprosy in India, the first point to be enquired into is the method employed. Anti-vaccinationists are accustomed to speak of the danger of spreading the disease by means of vaccination, as though the method of protective inoculation were uniform, and as though vaccination were exclusively practised from arm to arm with human lymph, or from arm to arm.

If leprosy be transmissible in this manner, it can only be by vaccination with human lymph or through the use of unclean instruments. Now in the city of Bombay calf lymph is exclusively used, at the present time at least. In Madras the Government has also determined to introduce as rapidly as possible a complete system of vaccination involving the use of animal vaccine to the entire exclusion of human lymph, and similar steps are taken in other parts, as in Bengal, Assam, and Burma. There is also no doubt that calf lymph is at present extensively used all over India. Hence in calculating the chances of spreading purely human diseases by means of vaccination allowance must be made for the fact that a considerable number of persons by being vaccinated do not expose themselves to any such risk, for the danger of an infection by means of unclean instruments is infinitesimally small, and can therefore be disregarded. * Such an event presupposes that the person undergoing the process of vaccination is a leper, and this in the case of infants and children, to begin with, must be an extremely rare occurrence, and hardly more frequent in the case of adults. Again, it is more than probable that in the event of a confirmed leper offering himself for vaccination, the most neglectful operator would be roused to the most careful performance of his duty. Finally the person vaccinated from, or after, a leper must be in the proper state or predisposition to be infected by leprosy. The simultaneous occurrence of all these concomitant conditions is hardly conceivable.

It is impossible to state in figures to what extent animal

vaccine is employed, but careful enquiry has shown that the use of calf lymph is very considerable, and is steadily increasing in the different provinces of India. As, however, bovine lymph has been in use only during the last ten years, to give those who raised the cry the best of the argument, this fact will be neglected in the following lines, and it will be assumed that the operation is practised with human lymph only and from arm to arm.

Again, it must not be forgotten that as yet vaccination is by no means generally introduced into India. What percentage of the population has been vaccinated, it is difficult to say, but on enquiry from the most trustworthy sources, it is found to be the general belief that less than ten per cent. of the whole population are so protected.

The Commissioners have, in a great number of cases, questioned the lepers on this point, but the result obtained by them cannot be taken as trustworthy evidence, because they had to rely on the answers of uneducated people to questions often asked through an interpreter. An examination of the vaccination marks frequently conveyed no information, for the cutaneous leprosy lesions often so completely change or obliterate the scar, that it is impossible to say whether the patient has been vaccinated or not. The native's idea of vaccination is very indefinite, for he understands by the term "tika" any process leaving a scar on his body, and such operations are widely practised by the hakims and baidis. The only admissible evidence, therefore, is to be found in the statistical returns of the Sanitary Commissioner with the Government of India. Here again it must be remembered that the returns of native vaccinators are not absolutely trustworthy, for being obliged to submit a definite monthly return, they are very apt to increase this by recording fictitious cases.

This is mentioned to show that the figures obtainable from the Sanitary Commissioner's Report err rather on the side of overestimating the number of people vaccinated, that

is, the number of people who according to some anti-vaccinationists have run the risk of acquiring such diseases as syphilis or leprosy.

It appears that during the year 1889-90 of 199,638,558 individuals only 2.9 per cent. were vaccinated, and this ratio has never been exceeded since the institution of vaccination. Were the operation generally practised, this ratio should be much higher, considering that vaccination is still in its infancy in India.

Of the six millions vaccinated in India during 1889-1890 about five millions were infants. The number of vaccinations annually performed has gradually increased from two millions in 1871-1872 to six millions in 1889-1890, and the ratio obtained for the latter period is the highest yet reached. Ever since the official introduction of vaccination into India, children under six-years of age have supplied the greatest number to the vaccinators. Now the death-rate of infants is extremely high and has always been so. Considering, therefore, that since the institution of vaccination never more than three per cent. of the total population have been operated upon during any one year, that of this number more than 75 per cent. are always infants, and that the mortality among the latter is very high, it is by no means improbable that at the present time less than ten per cent. of the total population in India are actually vaccinated.

The following statement will also show to what a small extent vaccination is as yet practised in India. "In England and Wales of 886,198 births returned to the Board by the several vaccination officers, as registered during the year 1887, the number which at the time the return was made had been registered as successfully vaccinated was 733,986, or 82.8 per cent. of the whole, and if revaccinations are included, this percentage rises to 91.9." In India, on the other

(*) Nineteenth Annual Report of the Local Government Board. Supplement. Appendix A., No. 1, page 1.

hand, estimating the births at forty per one thousand of the population, the average percentage of annual estimated births successfully vaccinated amounts only to about thirty per cent. (1889-1890):—

PROVINCE.	Percentage of annual estimated births successfully vaccinated (1889-1890).
Bengal	12.3
North-Western Provinces and Oudh	18.4
Punjab	63.9
Central Provinces	47.4
Berar	78.3
Lower Burma	11.1
Assam	8.3
Madras	14.3
Bombay	58.1

Having shown that only a comparatively small number of the natives are as yet vaccinated, an enquiry will be made into the danger of diffusing leprosy through this channel:—

- (a) It must be remembered, that as this will be further discussed in Chapter V, leprosy is not a disease which, like syphilis, can easily and with certainty be transmitted by a single inoculation.
- (b) Taking the births only, not more than about thirty per cent. are annually successfully vaccinated in their first year, and probably not more than forty per cent. of the children are vaccinated in their first six years. With a population of two hundred millions and a birth-rate of 3.4 per cent., in the specified provinces about two-and-a-half million children are vaccinated in their first year, and two-and-three-quarter millions in their first six years, so

that only about two-and-three-quarter millions expose themselves to the possible risk of acquiring leprosy by means of vaccination.

- (c) To be infected these children must have been vaccinated from a leper child. Now leprosy is found in about one out of two thousand individuals of all ages, and it is certainly not found as often as in one out of one hundred thousand cases at an infantile period.

- (d) Lastly, the error of using lymph from a leprosy child, especially as the disease is easily recognised, must occur extremely seldom.

The chances, therefore, of leprosy being spread in this manner must be very small indeed, if at all conceivable. Vaccination is becoming more popular every year, and yet leprosy has not increased, but rather decreased since the last enumeration: that "recrudescence," assumed by many, has not taken place, so far as the census figures show. The latter, however, have always been employed as evidence by those who condemned vaccination or clamoured for compulsory segregation.

Lastly, reference must be made to some important evidence which has lately become public. Surgeon-Major Pringle, in a paper on "Vaccination and Leprosy" read before the late Congress of Hygiene and Demography, stated that for a period of twenty years from 1864 to 1884, when Deputy Sanitary Commissioner in the North-Western Provinces, he had spent five months each year in camp in the hill districts of Kumaun and British Garhwal. He estimated that during these twenty years he had vaccinated about two million persons, but he had never seen a case of leprosy traceable to vaccination, and had never heard of its happening, though natives of those districts were ready with objections and reasons for not having their children vaccinated.

Dr. Pringle also stated that during his tenure of office he was in the habit at the end of the hot weather of bringing

vaccine lymph down from British Garhwal, a markedly leprosy district, and using it for vaccinating in that part of the plains included between the rivers Ganges and Jumna. Now, the first census returns (1867-72) show that, whereas the proportion of lepers in British Garhwal was 24.0 per ten thousand, that in the plains between the rivers was only 2.25 to 2.5 per ten thousand.

Here, then, is an approximation to a scientific experiment. Children in a district where leprosy is comparatively rare are vaccinated with lymph from a district where leprosy is many times more common. If vaccination were responsible for spreading leprosy, an increase of the disease in this particular part of India might justly be expected.

As a matter of fact, however, on comparing the census returns for the districts in question, the following will be found to be the facts:—

<i>British Garhwal.</i>	<i>District between the Ganges and Jumna.</i>
1867-72 . 24.0 per 10,000	2.25 to 2.5 per 10,000
1881 . 18.1 per 10,000	2.25 to 2.5 per 10,000
1891 . 16.9 per 10,000	1.5 to 2.0 per 10,000

Thus not only has leprosy fallen in British Garhwal from 24.0 to 16.9 per ten thousand, but in the district vaccinated with lymph from British Garhwal the proportion of lepers has remained stationary, if not decreased.

As Dr. Pringle was on duty, as stated above, from 1864 to 1884, and the number vaccinated with his lymph was gradually accumulating all these years, even allowing for removal by death and other counteracting influences, such as the diminution of leprosy in British Garhwal, it should be expected that by 1881 and 1891 the figures would show some evidence of the increase of leprosy which is alleged to follow the use of lymph collected in leprosy districts. This increase, however, does not appear in the census returns.

In conclusion, those who accuse vaccination of spreading leprosy must first ensure the correctness of their major premise

that leprosy has increased. It may be said that they argued exclusively from the first two censuses. But even then it will be seen that these establish a decrease of leprosy in Burma, Bombay, the Punjab, and Oudh. Again, the conditions under which vaccination is practised in India should be carefully studied as to how far animal and how far human lymph is employed, and whether leprosy has increased in those provinces or districts in which the human lymph is used. Lastly, they must bring the positive proof that leprosy is capable of being transmitted by such a form of inoculation as is implied in vaccination. The *onus probandi* necessarily rests with those who make the accusation, and until a series of positive cases, free from all doubt and objection, can be demonstrated, the statement that leprosy is diffused by vaccination must be regarded as devoid of scientific value.

Concluding Remarks.

It has been maintained by many writers that leprosy in British India is on the increase. Medical and lay papers agree on this point. Thus the British Medical Journal⁽⁴⁹⁾ asserts that the number of lepers has been increasing at the rate of thirty thousand every ten years, and that during the last decennium the rate of increase is supposed to have been even higher. That this is not so has been already shown.

The number of lepers has been estimated at two hundred and fifty thousand.⁽⁵⁰⁾ The only means of testing this is a comparison of the census returns. Now, according to the first census for British India, the number amounted to about a hundred thousand, and for 1881 it was one hundred and twenty thousand, while for 1891 it is about one hundred and ten thousand. As shown in the general remarks, from five to ten per cent. may justly be subtracted, so that from a hundred

(49) British Medical Journal, September 13th, 1890.

(50) Journal of the Leprosy Investigation Committee, No. 1.

thousand to one hundred and five thousand would fairly accurately represent the leper population for British India.

From the consideration of the leper distribution according to the three censuses, it is evident that the alarm about the increase of leprosy in British India is altogether groundless; in fact, that the figures available, unfortunately consisting only of three sets, point strongly to a decrease among these unfortunate people, in any case to the disease being at a standstill. Again, the number of lepers has been greatly overstated, a hundred and ten thousand being perhaps nearest the truth. Leprosy cannot, therefore, be regarded in the light of an "Imperial Danger."

In the following appendix full information regarding the leper population will be found. As at the time of writing the returns for 1891 had not been fully revised, a few inaccuracies may perhaps have found their way into the third part of the appendix; they will, however, be slight and hardly affect the ratios.

The Commissioners take this opportunity of recording their appreciation of the assistance afforded by their clerk, Lala Atar Chand, in the preparation of these statistical tables.

APPENDIX TO CHAPTER III.

Distribution of Lepers in the various Provinces of India according to the three Census Returns.

IN a few instances the figures in this Appendix disagree with the returns of the Imperial Census Reports. As, however, the latter often include in their totals areas where no leper census was taken, and such areas have been carefully omitted here, and again as the official returns were otherwise checked, such discrepancies are only apparent. In the Assam census of 1881, for instance, no special attention was paid to infirmities in the Naga and Garo Hill districts, and these were consequently left out. Again, in Bengal, no information regarding the Chittagong Hill Tracts was available. These examples may suffice. It is, of course, quite possible, and even probable, while dealing with so great a mass of figures and ratios, that a few errors and omissions have escaped detection, but these will be so slight as not to affect the arguments in the text.

Distribution of Lepers in the various Provinces of India according to the Census of 1867-72.

(a) By Divisions.

Name of Province or Presidency.	Division.	Year of Census	Total Population on which the Lepers-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Bengal . .	Burdwan . .	1872	7,285,957	12,081	16.5	
	Presidency . .		6,545,464	3,682	5.6	
	Rajshahye . .		8,893,738	6,182	6.9	
	Cooch Behar . .		422,597	244	5.7	
	Dacca . .		9,517,493	5,297	5.5	
	Chittagong . .		3,444,874	915	2.6	
	TOTAL FOR BENGAL PROPER . .		35,111,238	28,403	7.8	
	Patna . .		13,122,743	5,742	4.3	
	Bhagalpur . .		6,613,358	2,031	3.0	
	TOTAL FOR BEHAR . .		19,736,101	7,773	3.9	
	Orissa . .		4,317,999	1,077	2.4	
	TOTAL FOR ORISSA . .		4,317,999	1,077	2.4	
Assam . .	Chota Nagpur* . .	1872	2,182,468	567	2.5	
	TOTAL FOR CHOTA NAGPUR . .		2,182,468	567	2.5	
	TOTAL FOR BENGAL . .		62,347,796	37,820	6.0	
	Assam . .		1,879,650	309	1.6	
	TOTAL FOR BENGAL, INCLUDING ASSAM . .		64,227,446	38,129	5.9	

* No returns of infirmities were made from the Lohardugga District or the Tributary Mehals.

Distribution of Lepers, etc., 1867-72.

Name of Province or Presidency.	Division.	Year of Census	Total Population on which the Lepers-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
North-Western Provinces.	Meerut . .	1872	4,973,190	1,463	2.9	
	Rohilkund . .		5,435,550	2,256	4.2	
	Agra . .		5,038,136	1,145	2.2	
	Jhansi . .		934,747	211	2.2	
	Allahabad . .		5,466,116	1,828	3.3	
	Benares . .		8,178,147	1,625	1.9	
	Kumaun . .		743,170	1,571	21.1	
	TOTAL FOR NORTH-WESTERN PROVINCES . .		30,769,056	10,099	3.2	
Oudh . .	Lucknow . .	1869	2,570,950	1,758	6.8	
	Rae Bareilly . .		2,648,950	1,854	6.9	
	Fyzabad . .		3,379,262	2,364	6.9	
	Sitapur . .		2,604,882	1,855	7.1	
	TOTAL FOR OUDH . .		11,204,044	7,831	6.9	
	TOTAL FOR NORTH-WESTERN PROVINCES AND OUDH . .		41,973,100	17,930	4.2	
Punjab . .	Delhi . .	1868	1,916,423	1,273	6.6	
	Hissar . .		1,232,435	605	4.9	
	Umballa . .		1,652,728	1,524	9.2	
	Jullundur . .		2,477,536	2,758	11.1	
	Amritsar . .		2,743,880	1,774	6.4	
	Lahore . .		1,889,495	633	3.3	
	Rawalpindi . .		2,197,387	1,613	7.3	
	Mooltan . .		1,474,574	452	3.0	
	Derajat . .		991,251	153	1.5	
	Peshawar . .		1,035,789	204	1.9	
	TOTAL FOR THE PUNJAB . .		17,611,498	10,989	6.2	
Central Provinces.	Nagpur . .	1868	2,280,081	892	3.9	
	Jubbulpore . .		1,946,574	137	.7	
	Nerbadda . .		1,590,907	550	3.4	

Name of Province or Presidency.	Division.	Year of Census.	Total Population on which the leper-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Central Provinces— <i>contd.</i>	Chhattisgarh . . .	1868	2,331,837	629	2.6	
	Upper Godavari . . .		52,120	10	1.9	
	TOTAL FOR BRITISH DISTRICTS . . .		8,201,519	2,218	2.7	
	Total for Feudatory States . . .		1,049,710	589	5.6	
	TOTAL* FOR THE CENTRAL PROVINCES, INCLUDING FEUDATORY STATES . . .		9,251,229	2,807	3.0	
Berar . . .	Berar . . .	1867	2,231,565	1,432	6.4	
GRAND TOTAL FOR THE PRESIDENCY OF BENGAL.	British Territory.		134,245,123	70,698	5.2	
	Feudatory States.		1,049,710	589	5.6	
	TOTAL.		135,294,838	71,287	5.2	
	Ganjam . . .		1,383,976*	698	5.0	
	Vizagapatam . . .		1,844,711†	586	3.1	
Madras	Godavari . . .	1871	1,592,939	654	4.1	
	Kistna . . .		1,452,374	517	3.5	
	Nellore . . .		1,376,811	543	3.9	
	Cuddapah . . .		1,351,194	495	2.9	
	Bellary . . .		1,668,006	631	3.7	
	Kurnool . . .		959,640	349	3.6	
	Chingleput . . .		938,184	580	6.1	
	North Arcot . . .		2,015,278	1,253	6.2	
	South Arcot . . .		1,755,817	849	4.8	
	Tanjore . . .		1,973,731	1,430	7.3	
	Trinchinopoly . . .		1,200,408	343	2.8	
	Madura . . .		2,206,615	659	2.9	
	Tinnevely . . .		1,693,959	810	4.7	
	Coimbatore . . .		1,763,274	399	2.2	
	Nilgiris . . .		49,501	41	8.2	
	Salem . . .		1,966,995	554	2.8	
	South Canara . . .		918,362	748	8.1	

* Exclusive of the population of Mallah villages.
† Exclusive of the population of Jeypore.

Name of Province or Presidency.	Division.	Year of Census.	Total Population on which the leper-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Madras— <i>contd.</i>	Malabar . . .	1871	2,261,250	1,378	6.0	
	Madras . . .		397,552	418	10.5	
	TOTAL FOR BRITISH DISTRICTS . . .		39,835,577	13,847	4.4	
	Total for Feudatory States . . .		316,595	97	3.0	
	TOTAL FOR THE MADRAS PRESIDENCY, INCLUDING FEUDATORY STATES . . .		31,152,272	13,944	4.4	
British Burma	Arakan . . .	1872	484,363	185	3.8	
	Pegu . . .		1,662,058	2,072	12.4	
	Tenasserim . . .		600,727	946	15.7	
	TOTAL FOR BRITISH BURMA . . .		* 2,747,148	3,203	11.6	
Bombay	Deccan . . .	1872	7,966,061	9,246	11.6	The returns for the military and civil cantonments and the railways have been excluded to obviate confusion. They will, however, be found further on in the more detailed statement.
	Konkan . . .		3,259,776	2,753	8.4	
	Gujarat . . .		2,810,522	1,534	5.4	
	Sind . . .		2,192,415	309	1.4	
	TOTAL FOR THE BRITISH DISTRICTS OF BOMBAY . . .		16,228,774	13,842	8.5	
	Total for Bombay Feudatory States . . .		7,634,413	4,952	6.4	
	TOTAL OF BOMBAY PRESIDENCY, INCLUDING FEUDATORY STATES . . .		23,863,187	18,794	7.8	
Mysore	Mysore . . .	1871	5,055,412	1,497	2.9	
Coorg . . .	Coorg . . .	1871	168,312	82	4.8	
GRAND TOTAL FOR INDIA, BRITISH TERRITORY			184,056,627	101,590	5.5	
	GRAND TOTAL FOR INDIA, FEUDATORY STATES . . .		14,224,542	7,217	5.0	
	GRAND TOTAL FOR INDIA, INCLUDING FEUDATORY STATES . . .		198,281,169	108,807	5.4	

Distribution of Lepers in the various Provinces of India according to the Census of 1867-72 — contd.

(b) By Districts.

Division.	District.	Total Population on which the Lepers have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Burdwan	Bengal.				
	Burdwan .	2,034,745	4,604	22.6	
	Bankoora .	526,772	1,578	29.9	
	Deerbhoom .	695,921	2,872	41.2	
	Midnapore .	2,540,963	2,127	8.3	
	Hooghly, with Howrah .	1,483,356	900	6.0	
	TOTAL FOR BURDWAN DIVISION .	7,286,957	12,081	16.5	
Presidency.	24 Pergunnahs .	2,219,047	890	4.0	
	Calcutta .	447,601	324	7.2	
	Nuddea .	1,312,795	1,762	9.7	
	Jessore .	2,075,021	706	3.4	
	TOTAL FOR PRESIDENCY .	6,545,464	3,682	5.6	
Rajshahye	Moorshedabad .	1,353,626	1,776	13.1	
	Dinagepore .	1,501,924	573	3.8	
	Malda .	676,426	355	5.2	
	Rajshahye .	1,310,729	274	2.0	
	Rungpore .	2,149,972	2,302	10.7	
	Bogra .	689,467	387	5.6	
	Pubna .	1,211,594	515	4.2	
	TOTAL FOR RAJSHAHYE .	8,893,738	6,182	6.9	
Cooch Behar.	Darjeeling .	94,712	95	10.0	
	Jalpaiguri .	327,985	149	4.5	
	TOTAL FOR COOCH BEHAR .	422,697	244	5.7	

Division.	District.	Total Population on which the Lepers have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Dacca	Bengal—contd.				
	Dacca .	1,852,693	852	4.5	
	Furcedpore .	1,012,589	417	4.1	
	Backergunge .	2,377,433	439	1.8	
	Mymensingh .	2,349,917	1,762	7.4	
	Sylhet .	1,719,539	1,732	10.0	
	Cachar .	205,027	97	4.7	
	TOTAL FOR DACCAs .	9,517,498	5,295	5.5	
Chittagong.	Chittagong .	1,127,402	227	2.0	
	Noakholly .	713,934	55	.7	
	Tipperah .	1,533,931	633	4.1	
	Chittagong Hill Tracts .	69,607	...	...	
	TOTAL FOR CHITTAGONG .	3,444,874	915	2.6	
	TOTAL FOR BENGAL PROPER .	36,111,228	28,403	7.8	
Patna	Patna .	1,559,638	653	7.1	
	Gya .	1,949,759	1,912	9.8	
	Shahabad .	1,723,974	1,043	6.0	
	Tirhoot .	4,384,706	1,138	2.5	
	Sarun .	2,063,860	689	3.3	
	Chumparun .	1,440,815	305	2.1	
	TOTAL FOR PATNA .	13,122,743	5,742	4.3	
Bhagalpur	Monghyr .	1,812,986	539	3.0	
	Bhagalpur .	1,826,290	582	3.1	
	Purneah .	1,714,795	385	2.2	
	Sonthal Pergunnahs .	1,259,287	515	4.0	
	TOTAL FOR BHAGALPUR .	6,613,358	2,031	3.0	
	TOTAL FOR BEHAR .	19,736,101	7,773	3.9	9

Division.	District.	Total Population on which the Leprosy ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Orissa	Bengal—concd.				
	Cuttack . .	1,494,784	446	2.9	
	Pooree . .	769,674	256	3.3	
	Balasore . .	770,232	194	2.5	
	Tributary Mehals	1,283,309	181	1.4	
	TOTAL FOR ORISSA . .	4,317,999	1,077	2.4	
Chota Nagpur.	Hazaribagh . .	171,375	11	.1	
	Singhbhoom . .	415,023	13	.3	
	Manbhoom . .	995,570	543	5.4	
	TOTAL FOR CHOTA NAG-PORE* . .	2,182,468	567	2.5	
	TOTAL FOR BENGAL . .	62,347,796	37,820	6.0	
Assam	Assam.				
	Goalpara . .	407,714	301	7.3	
	Kamrup . .	561,681	6	.1	
	Darrang . .	236,009	2	.03	
	Nowgong . .	256,390	...	...	
	Sibsagar . .	296,589	...	...	
	Lakhimpur . .	121,267	...	...	
	TOTAL FOR ASSAM . .	1,879,650	309	1.6	
	TOTAL FOR BENGAL, INCLUDING ASSAM	64,227,446	38,129	5.9	

* No returns of leprosy were made from the Lohardugga District or the Tributary Mehals.

Division.	District.	Total Population on which the Leprosy ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Meerut	North-Western Provinces.				
	Dera Dun . .	115,711	220	19.0	
	Saharanpur . .	883,782	95	1.0	
	Muzaffarnagar . .	690,082	227	3.2	
	Meerut . .	1,273,914	305	2.3	
	Bulandshahr . .	935,593	376	4.0	
	Aligarh . .	1,073,108	240	2.2	
	TOTAL FOR MEERUT . .	4,973,190	1,463	2.9	
Rohilcund	Bijnor . .	737,152	193	2.6	
	Moradabad . .	1,122,131	649	5.7	
	Budaun . .	934,348	431	4.6	
	Bareilly . .	1,506,801	421	2.7	
	Shahjahanpur . .	949,471	540	5.6	
	Tarai . .	185,647	22	1.1	
	TOTAL FOR ROHILCUND . .	5,435,550	2,256	4.2	
Agra	Muttra . .	887,355	122	1.3	
	Agra . .	1,094,184	320	2.9	
	Farukhabad . .	918,748	163	1.7	
	Mainpuri . .	765,783	94	1.2	
	Etawah . .	668,581	59	.8	
	Etah . .	703,485	387	5.5	
	TOTAL FOR AGRA . .	5,038,136	1,145	2.2	
Jhansi	Jalaun . .	404,384	123	3.0	
	Jhansi . .	317,735	58	1.8	
	Lalitpur . .	212,628	30	1.4	
	TOTAL FOR JHANSI . .	934,747	211	2.2	

DIVISION.	District.	Total Population on which the Leper-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Allahabad	North-Western Provinces—contd.				
	Cawnpore .	1,155,439	219	1'8	
	Fatehpur .	667,815	140	2'1	
	Banda .	697,611	918	13'1	
	Allahabad .	1,394,245	173	1'2	
	Hamirpur .	529,137	291	5'4	
	Jaunpur .	1,025,869	87	'8	
	TOTAL FOR ALLAHABAD .	5,466,116	1,828	3'3	
Benares	Azamgarh .	1,531,410	169	1'1	
	Mirzapur .	1,015,293	250	1'9	
	Benares .	793,699	285	3'5	
	Ghazipur .	1,345,401	371	2'7	
	Gorakhpur .	2,019,350	465	2'3	
	Basti .	1,472,994	135	'9	
	TOTAL FOR BENARES .	8,178,147	1,625	1'9	
Kumaun	Kumaun .	432,888	824	19'0	
	Garhwal .	310,282	747	24'0	
	TOTAL FOR KUMAUN .	743,170	1,571	21'1	
	TOTAL FOR THE NORTH-WESTERN PROVINCES	30,769,036	10,099	3'2	

DIVISION.	District.	Total Population on which the Leper-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Lucknow	Oudh.				
	Lucknow .	970,625	679	6'9	
	Bara Banki .	875,376	572	6'5	
	Unao .	724,949	507	6'9	
	TOTAL FOR LUCKNOW .	2,570,950	1,758	6'8	
Rae Bareilly	Rae Bareilly .	782,874	548	6'9	
	Sultanpur .	930,023	651	6'9	
	Partabgarh .	935,053	655	6'9	
	TOTAL FOR RAE BAREILLY .	2,648,950	1,854	6'9	
Fyzabad	Fyzabad .	1,437,009	1,005	6'9	
	Gonda .	1,167,816	817	6'9	
	Bahraich .	774,437	542	6'9	
	TOTAL FOR FYZABAD .	3,379,262	2,364	6'9	
Sitapur	Sitapur .	930,224	651	6'9	
	Hardoi .	936,926	688	7'3	
	Kheri .	737,732	516	6'9	
	TOTAL FOR SITAPUR .	2,604,882	1,855	7'1	
	TOTAL FOR OUDH	11,204,044	7,831	6'9	
	TOTAL FOR THE NORTH-WESTERN PROVINCES AND OUDH	41,973,100	17,930	4'2	

The leper census for Hardoi was taken with great care, but in the other eleven districts of Oudh, the total numbers and ratios of lepers were merely estimated according to the proportions found in Hardoi (cf. Census of Oudh, 1869, Vol. I, page 150).

N.B.—Except Hardoi the figures for population and lepers given in the other eleven districts of the Oudh Division are only estimated.

DIVISION.	District.	Total Population on which the Leper-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Delhi	Punjab.				
	Delhi . .	608,850	320	5.2	
	Gurgaon . .	696,646	621	8.9	
	Karnal . .	610,927	332	5.4	
	TOTAL FOR DELHI . .	1,916,423	1,273	6.6	
Hissar	Hissar . .	484,681	253	5.2	
	Rohtak . .	536,959	291	5.4	
	Sirsa . .	210,795	61	2.8	
	TOTAL FOR HISSAR . .	1,232,435	605	4.9	
Umballa	Umballa . .	1,035,488	946	9.1	
	Ludhiana . .	583,245	460	7.8	
	Simla . .	33,995	118	34.7	
	TOTAL FOR UMBALLA . .	1,652,728	1,524	9.2	
Jullundur	Jullundur . .	794,764	518	6.5	
	Hoshiarpur . .	938,890	901	9.5	
	Kangra . .	743,882	1,339	18.0	
	TOTAL FOR JULLUNDUR . .	2,477,536	2,758	11.1	
Amritsar	Amritsar . .	1,083,514	690	6.3	
	Sialkot . .	1,005,004	651	6.4	
	Gurdaspur . .	655,362	433	6.6	
	TOTAL FOR AMRITSAR . .	2,743,880	1,774	6.4	

DIVISION.	District.	Total Population on which the Leper-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Lahore	Punjab—contd.				
	Lahore . .	789,666	106	1.3	
	Ferozepore . .	549,253	356	6.4	
	Gujranwala . .	550,576	171	3.1	
	TOTAL FOR LAHORE . .	1,889,495	633	3.3	
Rawalpindi	Rawalpindi . .	711,256	742	10.4	
	Jhelum . .	500,988	376	7.5	
	Gujrat . .	616,347	423	6.8	
	Shahpur . .	368,796	72	1.9	
	TOTAL FOR RAWALPINDI . .	2,197,387	1,613	7.3	
Mooltan	Mooltan . .	471,563	214	4.5	
	Jhang . .	348,027	42	1.2	
	Montgomery . .	359,437	40	1.1	
	Muzaffargarh . .	295,547	156	5.2	
	TOTAL FOR MOOLTAN . .	1,474,574	452	3.0	
Derajat	Dera Ismail Khan . .	394,864	21	.5	
	Dera Ghazi Khan . .	308,840	88	2.8	
	Bannu . .	287,517	44	1.5	
	TOTAL FOR DERAJAT . .	991,251	153	1.5	
Peshawar	Peshawar . .	523,152	59	1.1	
	Kohat . .	145,419	5	.3	
	Hazara . .	367,218	140	3.8	
	TOTAL FOR PESHAWAR . .	1,035,789	204	1.9	
	TOTAL FOR THE PUNJAB . .	17,611,498	10,989	6.2	

Division.	District.	Total Population on which the Leper-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Nagpur	Central Provinces.				
	Nagpur . .	631,109	249	3.9	
	Bhandara . .	564,813	71	1.2	
	Chanda . .	534,431	326	6.0	
	Wardha . .	354,720	242	6.8	
	Balaghat . .	195,008	4	.2	
	TOTAL FOR NAGPUR . .	2,280,081	892	3.9	
Jubbulpore.	Jubbulpore . .	528,859	13	.2	
	Saugor . .	527,745	94	1.7	
	Damoh . .	269,642	7	.2	
	Seoni . .	407,330	21	.5	
	Mandla . .	213,018	2	.09	
	TOTAL FOR JUBBULPORE . .	1,946,574	137	.7	
Narbada	Betul . .	284,055	49	1.7	
	Chhindwara . .	316,095	71	2.2	
	Hoshangabad . .	440,186	136	3.0	
	Narsinghpur . .	339,395	100	2.9	
	Nimar . .	211,176	194	9.1	
	TOTAL FOR NARBADA . .	1,590,907	550	3.4	
Chhattisgarh.	Raipur . .	1,093,405	296	2.7	
	Bilaspur . .	715,398	170	2.3	
	Sambalpur . .	523,031	163	3.1	
	TOTAL FOR CHHATTISGARH . .	2,331,837	629	2.6	
	Upper Godavari . .	52,120	10	1.9	
	TOTAL FOR BRITISH DISTRICTS . .	8,201,519	2,218	2.7	
	Total for Feudatory States . .	1,049,710	589	5.6	
	TOTAL FOR THE WHOLE CENTRAL PROVINCES (INCLUDING FEUDATORY STATES) . .	9,251,229	2,807	3.0	

Division.	District.	Total Population on which the Leper-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Berar	Berar.				
	Akola . .	649,134	348	5.3	
	Mehkar . .	353,436	351	9.9	
	Amraoti . .	497,276	278	6.8	
	Ellichpur . .	344,688	193	5.6	
	Wua . .	477,361	262	5.4	
	TOTAL FOR BERAR . .	2,231,565	1,432	6.4	
Madras	Madras.				
	Ganjam . .	1,388,976*	698	5.0	
	Vizagapatam . .	1,844,711†	586	3.1	
	Godavari . .	1,592,939	654	4.1	
	Kistna . .	1,452,374	517	3.5	
	Nellore . .	1,376,811	545	3.9	
	Cuddapah . .	1,351,194	405	2.9	
	Bellary . .	1,668,006	631	3.7	
	Kurnool . .	939,640	349	3.6	
	Chingleput . .	938,184	580	6.1	
	North Arcot . .	2,015,278	1,253	6.2	
	South Arcot . .	1,755,817	849	4.8	
	Tanjore . .	1,973,731	1,430	7.2	
	Trichinopoly . .	1,200,408	343	2.8	
	Madura . .	2,266,615	659	2.9	
	Tinnevely . .	1,693,959	810	4.7	
	Coimbatore . .	1,763,274	399	2.2	
	Nilgiris . .	49,501	41	8.2	
	Salem . .	1,966,995	554	2.8	
	South Canara . .	918,362	748	8.1	
	Malabar . .	2,261,250	1,378	6.0	
	Madras . .	397,552	418	10.5	
	TOTAL FOR BRITISH DISTRICTS . .	30,835,577	13,847	4.4	
	Pudukota Territory . .	316,695	97	3.0	
	TOTAL FOR THE MADRAS PRESIDENCY, INCLUDING THE FEUDATORY STATE OF PUDUKOTA . .	31,152,272	13,944	4.4	

* Exclusive of the population of Maliah villages.

† Exclusive of the population of Jey, etc.

DIVISION.	District.	Total Population on which the Leper-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Arakan	British Burma.				
	Akyab . . .	276,671	79	2.8	
	North Arakan . .	8,790	25	28.4	
	Ramree . . .	144,177	58	4.0	
	Sandoway . . .	54,725	22	4.2	
	TOTAL FOR ARAKAN . .	484,363	185	3.8	
Pegu	Rangoon . . .	332,324	569	17.1	
	Rangoon Town . .	98,745	164	10.5	
	Bassein . . .	322,689	398	12.3	
	Myanaung . . .	476,612	565	11.8	
	Prome . . .	274,872	266	9.6	
	Thayetmyo . . .	156,816	170	10.8	
	TOTAL FOR PEGU . .	1,662,058	2,072	12.4	
Tenasserim.	Moulmein Town . .	46,472	57	12.2	
	Amherst . . .	193,468	286	14.7	
	Tavoy . . .	71,827	54	7.5	
	Mergui . . .	47,192	46	9.7	
	Shwegyin . . .	129,485	229	17.6	
	Toungoo . . .	86,166	272	31.5	
	Salween . . .	26,117	2	.7	
	TOTAL FOR TENASSERIM . .	600,727	946	15.7	
	TOTAL FOR BRITISH BURMA . .	2,747,148	3,203	11.6	
Deccan	Bombay.				
	Khandesh . . .	1,028,642	1,532	14.8	It appears from the Census Report that cases of "Leukoderma" were generally included under Leprosy. In a few districts (Belgaum, Panch Mahals, Kurrachee, and Hyderabad) a distinction was drawn between "white" and "black or true" leprosy. The figures in brackets signify the numbers and percentages of true lepers for the specified districts. This shows how carefully and critically census figures must be studied. Similar mistakes must occur in all census returns, and thus all statements, as to a rapid increase of leprosy in India, based on such figures, must be impartially weighed and accurately examined.
	Nasik . . .	734,556	716	9.7	
	Ahmednagar . . .	773,938	1,085	14.0	
	Poona . . .	907,235	1,090	12.0	
	Satara . . .	1,116,050	1,321	11.8	
	Sholapur . . .	662,986	795	11.9	
	Belgaum . . .	938,750	(483)943	(5.1)10.0	
	Dharwar . . .	988,037	1,155	11.6	
	Kaladgi . . .	816,037	607	7.4	
	TOTAL FOR DECCAN . .	7,966,061	9,246	11.6	

DIVISION.	District.	Total Population on which the Leper-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Konkan	Bombay—contd.				
	Kanara . . .	398,405	158	3.9	
	Ratnagiri . . .	1,019,136	1,237	12.1	
	Kolaba . . .	350,405	444	12.6	
	Town and Island of Bombay . .	644,405	209	3.2	
	Thana . . .	847,424	705	8.3	
	TOTAL FOR KONKAN . .	3,259,776	2,753	8.4	
Gujarat	Surat . . .	607,087	579	9.5	
	Broach . . .	350,322	188	5.3	
	Kaira . . .	782,733	411	5.2	
	Panch Mahals . .	240,743	(27)114	(11.1)4.7	
	Ahmedabad . . .	829,637	242	2.9	
	TOTAL FOR GUJARAT . .	2,810,522	1,534	5.4	
Sind	Kurrachee . . .	423,495	(9) 81	(2.1)1.9	It appears from the Census Report that cases of "Leukoderma" were generally included under Leprosy. In a few districts (Belgaum, Panch Mahals, Kurrachee, and Hyderabad) a distinction was drawn between "white" and "black or true" leprosy. The figures in brackets signify the numbers and percentages of true lepers for the specified districts. This shows how carefully and critically census figures must be studied. Similar mistakes must occur in all census returns, and thus all statements, as to a rapid increase of leprosy in India, based on such figures, must be impartially weighed and accurately examined.
	Hyderabad . . .	721,947	(6) 126	(.68)1.7	
	Thar and Parkar . .	180,761	8	.4	
	Shikarpur . . .	776,227	87	1.1	
	Upper Sind Frontier . .	89,985	7	.7	
	TOTAL FOR SIND . .	2,192,415	309	1.4	
	TOTAL FOR THE BOMBAY PRESIDENCY . .	15,228,774	13,842	8.5	
	Bombay Military Cantonments . .	81,228	6	.7	

DIVISIONS.	Districts.	Total Population on which the Leper-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Deccan	Bombay Civil Cantonments.				
	Mhow . . .	17,639	6	3.4	
	Baroda . . .	2,451	4	16.3	
	Aden . . .	19,289	3	1.5	
	Deesa . . .	9,335	2	2.1	
	Rajkot . . .	3,684	38*	103.1	
	TOTAL . . .	52,398	53	10.1	
	Bombay Railways	8,750	3	3.4	
	Bombay Feudatory States.				
	Kolhapur . . .	802,691	1,190	14.8	
	Akalkot . . .	81,068	37	4.5	
	Southern Maharastra Jagirs . . .	610,434	520	8.5	
	Satara Jagirs—				
	Phalton . . .	204,410	213	10.4	
	The Dangs . . .	59,124	47	7.9	
Konkan	Savanur . . .	39,111	22	5.6	
	Savanur . . .	17,288	23	13.3	
	TOTAL FOR DECCAN . . .	1,814,126	2,052	11.3	
Konkan	Savantvadi . . .	190,814	69	3.6	
	Janjira . . .	71,996	87	12.0	
	TOTAL FOR KONKAN . . .	262,810	156	5.9	
Gujarat	Thana Agency . . .	37,405	47	12.5	
	Baroda . . .	2,000,225	862	4.3	
	Kathiawar . . .	2,312,629	1,480	6.3	
	Rewa Kantha . . .	505,732	294	5.8	

* Affected with red leprosy.

DIVISION.	District.	Total Population on which the Leper-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Gujarat	Bombay Feudatory States—concl.				
	Mahi Kantha . . .	...	...	...	Information not obtainable.
	Palanpur . . .	...	...	...	
	Cambay . . .	83,494	3	3	
	Surat Agency	123,849	43	3.4	
	Jumbughoda . . .	6,837	...	...	
	Cutch . . .	487,305	15	3	
	TOTAL FOR GUJARAT . . .	5,557,477	2,744	4.9	
Sind	Khairpur . . .	...	...	...	Information not obtainable.
	TOTAL FOR SIND . . .	...	...	...	
	Total for Feudatory States . . .	7,634,413	4,952	6.4	
Mysore	Mysore.				
	Bangalore . . .	828,354	409	4.9	
	Kolar . . .	618,954	351	5.6	
	Tamkur . . .	632,239	143	2.2	
	Mysore . . .	943,187	150	1.5	
	Hassan . . .	668,417	116	1.7	
	Shimega . . .	498,976	158	3.1	
	Kadur . . .	333,925	60	1.7	
	Chitaldroog . . .	531,360	110	2.0	
	TOTAL FOR MYSORE . . .	5,055,412	1,497	2.9	
Coorg	Coorg . . .	168,312	82	4.8	

Distribution of Lepers in the various Provinces of India according to the Census of 1881.

(a) By Divisions.

Name of Province or Presidency.	DIVISION.	Total Population on which the Leper-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Bengal	Burdwan . . .	7,393,954	14,426	1.95	
	Presidency . . .	8,204,912	5,633	6.8	
	Rajshahiye . . .	7,733,775	7,170	0.2	
	Dacca . . .	8,700,939	4,934	5.6	
	Chittagong . . .	3,472,451	1,473	4.2	
	TOTAL FOR BENGAL PROPER . . .	35,506,031	33,636	9.4	
	Patna . . .	15,063,944	8,343	5.5	
	Bhagalpur . . .	8,063,100	5,060	6.2	
	TOTAL FOR BEHAR . . .	23,127,104	13,403	5.7	
	Orissa . . .	3,730,735	4,661	12.4	
	TOTAL FOR ORISSA . . .	3,730,735	4,661	12.4	
	Chota Nagpur . . .	4,225,989	2,274	5.3	
	TOTAL FOR CHOTA NAGPUR . . .	4,225,989	2,274	5.3	
	TOTAL FOR BENGAL . . .	66,582,850	53,974	8.1	
Assam	Total for Feudatory States . . .	2,749,768	2,549	9.2	
	TOTAL FOR BENGAL, INCLUDING FEUDATORY STATES . . .	69,339,627	56,523	8.1	
Assam	ASSAM . . .	4,701,412	3,314	7.0	

Distribution of Lepers, etc., 1881.

Name of Province or Presidency.	Division.	Total Population on which the Leper-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
North-Western Provinces and Oudh.	Meerut . . .	5,141,204	1,692	3.2	
	Agra . . .	4,834,064	840	1.7	
	Rohilkund . . .	5,122,557	2,984	5.8	
	Allahabad . . .	5,754,855	2,199	3.8	
	Benares . . .	9,820,728	3,559	3.6	
	Jhansi . . .	1,000,457	412	4.1	
	Kumaun . . .	1,046,263	1,690	16.1	
	TOTAL FOR THE NORTH-WESTERN PROVINCES . . .	32,720,128	13,379	4.0	
	Lucknow . . .	2,622,681	1,419	5.4	
	Sitapur . . .	2,777,803	1,107	3.9	
	Fyzabad . . .	3,230,393	1,032	3.1	
	Rae Bareilly . . .	2,756,864	885	3.2	
	TOTAL FOR OUDH . . .	11,387,741	4,443	3.9	
	TOTAL FOR THE NORTH-WESTERN PROVINCES AND OUDH . . .	44,107,869	17,822	4.0	
Total for Feudatory States	Total for Feudatory States . . .	741,750	433	5.8	
	TOTAL FOR THE NORTH-WESTERN PROVINCES AND OUDH, INCLUDING FEUDATORY STATES . . .	44,849,619	18,255	4.0	

Name of Province or Presidency.	Division.	Total Population on which the Leper-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Punjab	Delhi . . .	1,917,984	666	3.4	
	Hissar . . .	1,311,067	337	2.5	
	Umballa . . .	1,729,043	819	4.7	
	Jullundur . . .	2,421,781	1,843	7.6	
	Anritsar . . .	2,729,109	1,081	3.9	
	Lahore . . .	2,191,517	338	1.5	
	Rawalpindi . . .	2,520,508	1,158	4.5	
	Mooltan . . .	1,712,394	215	1.2	
	Derajat . . .	1,137,572	153	1.3	
	Peshawar . . .	1,181,289	269	2.2	
	TOTAL FOR THE PUNJAB . . .	18,842,264*	6,880	3.6	
Central Provinces.	Total for Feudatory States . . .	3,861,683	2,854	7.3	
	TOTAL FOR THE PUNJAB, INCLUDING FEUDATORY STATES . . .	22,703,947	9,734	4.2	
	Nagpur . . .	2,758,056	2,489	9.0	
	Jubbulpore . . .	2,201,633	624	2.8	
	Nerbadda . . .	1,763,105	930	5.2	
Berar	Chhattisgarh . . .	3,115,997	2,400	7.7	
	TOTAL FOR THE CENTRAL PROVINCES . . .	9,838,791	6,443	6.5	
	Berar . . .	2,672,673	3,748	14.0	
GRAND TOTAL FOR THE PRESIDENCY OF BENGAL.	BRITISH TERRITORY . . .	146,752,868	92,181	6.2	
	Feudatory States . . .	7,353,201	5,836	7.9	
	TOTAL . . .	154,106,069	98,017	6.3	

* Excluding Khaibar Pass.

Name of Province or Presidency.	Division.	Total Population on which the Leper-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Madras	Garjam . . .	1,503,301	613	4.0	
	Vizagapatam . . .	1,790,468	856	4.7	
	Godavari . . .	1,780,613	1,037	5.8	
	Kistna . . .	1,548,480	626	4.0	
	Nellore . . .	1,220,236	395	3.2	
	Cuddapah . . .	1,121,038	210	1.8	
	Kurnool . . .	709,305	246	3.4	
	Bellary . . .	1,336,696	356	2.6	
	Chingleput . . .	981,381	984	10.0	
	North Arcot . . .	1,817,814	1,161	6.3	
	South Arcot . . .	1,814,738	1,208	6.6	
	Tanjore . . .	2,130,383	1,072	5.0	
	Trichinopoly . . .	1,215,033	495	4.0	
	Madura . . .	2,168,680	812	3.7	
	Tinnevely . . .	1,699,747	802	4.7	
	Salem . . .	1,599,595	363	2.2	
	Coimbatore . . .	1,657,690	241	1.4	
	Nilgiris . . .	91,034	58	6.3	
	Malabar . . .	2,365,035	1,208	5.1	
	South Canara . . .	959,514	909	9.4	
British Burma.	Madras City . . .	405,848	435	10.7	
	TOTAL FOR THE BRITISH DISTRICTS OF MADRAS . . .	29,916,629	14,088	4.7	
	Total for Feudatory States . . .	1,254,002	437	3.4	
	TOTAL FOR THE PRESIDENCY OF MADRAS, INCLUDING FEUDATORY STATES . . .	31,170,631	14,525	4.6	
	Arakan . . .	587,518	169	2.8	
British Burma.	Pegu . . .	1,162,393	850	7.3	
	Irrawaddy . . .	1,161,119	1,114	9.5	
	Tenasserim . . .	825,741	456	5.5	
British Burma.	TOTAL FOR BRITISH BURMA . . .	3,736,771	2,589	6.9	

Name of Province or Presidency.	Division.	Total Population on which the Leper-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Bombay.	Gujrat . . .	2,857,731	810	2.8	
	Konkan . . .	2,287,287	2,109	9.2	
	Deccan . . .	5,315,123	5,774	10.8	
	Western Kar-natic . . .	2,807,254	695	2.4	
	Sind . . .	2,413,823	277	1.1	
	City and Island of Bombay . . .	773,196	430	5.5	
	Aden . . .	34,860	...	...	
	TOTAL FOR BRITISH TERRITORY . . .	16,489,274	10,095	6.1	
	Total for Feudatory States . . .	6,812,005	2,287	3.3	
	TOTAL FOR THE BOMBAY PRESIDENCY INCLUDING FEUDATORY STATES . . .	23,301,370	12,382	5.3	
Mysore .	Mysore . . .	4,186,188	533	1.2	
Coorg .	Coorg . . .	178,302	43	2.4	
Grand Total for India, British Territory . . .		196,895,542	118,953	6.0	
Grand Total for India, Feudatory States . . .		19,783,789	9,136	4.6	
Grand Total for India, including Feudatory States . . .		216,679,331	128,089	5.9	

Distribution of Lepers in the various Provinces of India according to the Census of 1881—contd.

(b) By Districts.

Division.	District.	Total Population on which the Leper-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Burdwan	Bengal.				
	Burdwan . . .	1,391,823	4,118	29.5	
	Bankoora . . .	1,041,752	3,877	37.2	
	Beerbhoom . . .	794,428	2,603	32.7	
	Midnapore . . .	2,517,802	2,338	9.2	
	Hooghly . . .	1,012,768	1,130	11.1	
	Howrah . . .	615,381	360	5.6	
	TOTAL FOR BURDWAN . . .	7,393,954	14,426	19.5	
	24-Pergunnahs . . .	1,618,420	829	5.1	
	Suburbs . . .	251,439	151	6.0	
Presidency.	Calcutta . . .	1,133,219	236	5.4	
	Nuddea . . .	2,617,847	1,916	9.4	
	Jessore . . .	1,577,219	637	4.0	
	Khoolna . . .	1,079,948	294	2.7	
	Mo-rshedabad . . .	1,226,790	1,570	12.7	
	TOTAL FOR PRESIDENCY . . .	8,204,612	5,633	6.8	
Rajshahye	Dinapore . . .	1,514,346	1,130	7.4	
	Rajshahye . . .	1,338,638	616	4.6	
	Rungpore . . .	2,097,964	3,140	14.9	
	Bogra . . .	734,358	497	6.7	
	Pubna . . .	1,311,728	847	6.4	
	Darjeeling . . .	155,179	184	1.8	
	Jalpaiguri . . .	581,562	756	12.9	
	TOTAL FOR RAJSHAHYE . . .	7,733,775	7,170	9.2	

DIVISION.	District.	Total Population on which the Lepers-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Dacca	Bengal—contd.				
	Dacca	2,116,350	1,204	5.6	
	Furreedpore	1,631,724	653	4.0	
	Backergunge	1,900,889	483	2.5	
	Mymensingh	3,051,966	2,594	8.4	
	TOTAL FOR DACCÀ	8,700,939	4,934	5.6	
Chittagong.	Chittagong	1,132,341	494	4.3	
	Noakholly	820,772	220	2.6	
	Tipperah	1,519,338	759	4.9	
	Chittagong Hill Tracts	...	...	...	Not available.
	TOTAL FOR CHITTAGONG	3,472,451	1,473	4.2	
	TOTAL FOR BENGAL PROPER	35,506,031	33,636	9.4	
Patna	Patna	1,756,856	1,348	7.6	
	Gya	2,124,682	2,020	9.5	
	Shahabad	1,964,909	1,614	8.2	
	Mozufferpore	2,582,060	793	3.0	
	Durbhunga	2,633,447	696	2.5	
	Sarun	2,280,382	1,242	5.4	
	Chumparun	1,721,608	630	3.6	
	TOTAL FOR PATNA	15,063,944	8,343	5.5	
Bhagalpur	Monghyr	1,969,774	1,064	5.4	
	Bhagalpur	1,966,158	984	5.0	
	Purneah	1,848,687	1,707	9.2	
	Malda	710,448	515	7.2	
	Sonthal Per-gunnahs	1,568,093	790	5.0	
	TOTAL FOR BHAGALPUR	8,063,160	5,060	6.2	
	TOTAL FOR BHAR	23,127,104	13,493	5.7	

DIVISION.	District.	Total Population on which the Lepers-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Orissa	Bengal—contd.				
	Cuttack	1,738,165	1,058	11.2	
	Pooree	883,487	1,213	13.6	
	Balasore	943,280	1,298	13.7	
	Angul	101,903	115	11.2	
	Banki	56,900	77	13.5	
	TOTAL FOR ORISSA	3,730,735	4,661	12.4	
Chota Nagpore.	Hazaribagh	1,104,742	226	2.0	
	Lohardugga	1,609,244	527	3.2	
	Singhbhoom	453,775	217	4.7	
	Manbhoom	1,058,228	1,304	12.3	
	TOTAL FOR CHOTA NAGPORE	4,225,989	2,274	5.3	
	TOTAL FOR BENGAL	66,589,859	53,974	8.1	
Feudatory States.	Cooch-Behar	602,624	1,282	21.2	
	Hill Tipperah	...	...	...	Not available.
	Tributary States, Orissa	1,469,142	1,130	7.6	
	Tributary States, Chota Nagpore	673,002	137	2.0	
	Total for Feudatory States	2,749,768	2,549	9.2	
	TOTAL FOR BENGAL, INCLUDING FEUDATORY STATES.	69,339,627	56,523	8.1	
	Assam.				
Surma Valley.	Cachar (Plains)	289,425	242	7.8	
	Cachar (Hill Tracts)	24,433	5		
	Sylhet	1,069,009	1,439	7.3	
	TOTAL FOR SURMA VALLEY	2,282,867	1,686	7.3	

DIVISION.	District.	Total Population on which the Lepers have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Brahmaputra Valley.	Assam--contd.				
	Caco Hills (Plains).	23,914	1	4	
	Goalpara .	445,232	515	11.5	
	Kamrup .	644,960	352	5.4	
	Darrang .	273,333	90	3.2	
	Nowgong .	310,579	122	3.9	
	Sibsagar .	379,274	320	8.6	
	Lakhimpur .	179,823	119	6.6	
	TOTAL FOR BRAHMAPUTRA VALLEY	2,249,185	1,519	6.7	
	Khasi and Jaintia Hills.	169,360	109	6.4	
Meerut.	TOTAL FOR THE PROVINCE OF ASSAM .	4,701,412	3,314	7.0	
	North-Western Provinces.				
	Delra Dun	144,070	288	19.9	
	Saharanpur .	979,544	223	2.2	
	Muzaffarnagar .	758,144	237	3.1	
	Meerut .	1,313,137	380	2.8	
	Behanishahr .	924,822	361	3.9	
	Aligarh .	1,021,187	201	1.9	
	TOTAL FOR MEERUT	5,141,204	1,692	3.2	
	Muttra .	671,690	90	1.3	
Agra	Agra .	974,636	116	1.1	
	Farrukhabad .	907,608	174	1.9	
	Mainpuri .	801,216	150	1.8	
	Etawah .	722,371	81	1.1	
	Etah .	756,523	230	3.0	
	TOTAL FOR AGRA	4,834,064	843	1.7	

DIVISION.	District.	Total Population on which the Lepers have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Rohilkund.	North-Western Provinces--contd.				
	Bijnor .	721,450	273	3.7	
	Moradabad .	1,155,173	1,248	11.6	
	Budaun .	906,451	364	4.0	
	Bareilly .	1,030,936	407	3.9	
	Shahjahanpur .	856,946	459	5.3	
	Pilibhit .	451,601	133	2.9	
	TOTAL FOR ROHILKUND	5,122,557	2,984	5.8	
	Allahabad				
	Cawnpore .	1,81,396	283	2.3	
Benares.	Fatehpur .	683,745	154	2.2	
	Banda .	698,608	856	12.2	
	Hamirpur .	507,337	175	5.4	
	Allahabad .	6,474,106	361	2.4	
	Jaunpur .	1,209,663	270	2.2	
	TOTAL FOR ALLAHABAD	5,754,855	2,199	3.8	
	Azamgarh .	1,604,654	189	1.1	
	Mirzapur .	1,136,796	396	3.4	
	Benares .	8,26,684	284	3.1	
	Ghazipur .	1,014,099	492	4.8	
Jhansi.	Gorakhpur .	2,617,120	958	3.6	
	Basti .	1,630,612	698	4.2	
	Balia .	924,763	512	5.5	
	TOTAL FOR BENARES	9,820,728	3,559	3.6	
	Jhansi .	333,227	162	4.8	
	Jalaun .	418,142	172	4.1	
	Lalitpur .	249,088	78	3.1	
	TOTAL FOR JHANSI	1,000,457	412	4.1	

REPORT OF THE LEPROSY COMMISSION:

DIVISION.	District.	Total Population on which the Leper-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Kumaun	North-Western Provinces - Almora . . .	493,641	1,032	21.0	
	Garhwal . . .	345,629	620	18.1	
	Tawal . . .	206,923	22	1.0	
	TOTAL FOR KUMAUN . . .	1,046,263	1,600	16.1	
	TOTAL FOR THE NORTH-WESTERN PROVINCES . . .	32,722,128	13,370	4.0	
Lucknow	Oudh.				
	Lucknow . . .	606,824	244	3.3	
	Unao . . .	892,069	319	3.5	
	Bara Banki . . .	1,006,788	856	8.3	
	TOTAL FOR LUCKNOW . . .	2,622,681	1,419	5.4	
Sitapur	Sitapur . . .	958,251	434	4.5	
	Hardoi . . .	987,630	344	3.4	
	Kheri . . .	831,922	320	3.9	
	TOTAL FOR SITAPUR . . .	2,777,803	1,107	3.9	
Fyzabad	Fyzabad . . .	1,081,419	378	3.4	
	Bahraich . . .	878,048	275	3.1	
	Gonda . . .	1,270,926	379	2.9	
	TOTAL FOR FYZABAD . . .	3,230,393	1,032	3.2	
Rae Bareilly	Rae Bareilly . . .	951,905	378	3.8	
	Sultanpur . . .	957,912	246	2.5	
	Partabgarh . . .	847,047	271	3.1	
	TOTAL FOR RAE BAREILLY . . .	2,756,864	885	3.2	
	TOTAL FOR OUDH . . .	11,387,741	4,443	3.9	
	TOTAL FOR THE NORTH-WESTERN PROVINCES AND OUDH . . .	44,107,869	17,822	4.0	

Distribution of Lepers, etc., 1881.

DIVISION.	District.	Total Population on which the Leper-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Feudatory States.	Rampur State . . .	541,914	126	2.3	
	Native Garhwal . . .	199,836	307	15.3	
	TOTAL FOR FEUDATORY STATES . . .	741,750	433	5.8	
	TOTAL FOR THE NORTH-WESTERN PROVINCES AND OUDH, INCLUDING FEUDATORY STATES . . .	44,849,619	18,255	4.0	
Delhi	Punjab.				
	Delhi . . .	643,515	243	3.7	
	Gurgaon . . .	641,848	232	3.6	
	Karnal . . .	622,621	191	3.0	
	TOTAL FOR DELHI . . .	1,907,984	666	3.4	
Hissar	Hissar . . .	504,183	139	2.7	
	Rohtak . . .	553,609	153	2.7	
	Sirsa . . .	253,275	45	1.7	
	TOTAL FOR HISSAR . . .	1,311,067	337	2.5	
Umballa	Umballa . . .	1,067,263	529	4.9	
	Ludhiana . . .	618,835	167	2.6	
	Simla . . .	42,945	123	28.6	
	TOTAL FOR UMBALLA . . .	1,729,043	819	4.7	
Jullundur	Jullundur . . .	789,555	243	3.0	
	Hoshiarpur . . .	901,381	54	6.0	
	Kangra . . .	730,845	1,000	14.5	
	TOTAL FOR JULLUNDUR . . .	2,421,781	1,844	7.6	
Amritsar	Amritsar . . .	293,266	395	4.4	
	Gurdaspur . . .	823,695	361	3.6	
	Sialkot . . .	1,012,148	385	3.8	
	TOTAL FOR AMRITSAR . . .	2,729,109	1,081	3.9	

Division.	District.	Total Population on which the Lepers have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Lahore	Punjab—contd.				
	Lahore	924,106	84	'9	
	Gujranwala	616,890	72	1'1	
	Ferozepore	650,519	182	2'7	
	TOTAL FOR LAHORE	2,191,517	338	1'5	
Rawalpindi.	Rawalpindi	821,512	412	5'0	
	Jhelum	589,373	227	3'8	
	Gujrat	639,115	429	6'2	
	Shahpur	421,508	90	2'1	
	TOTAL RAWALPINDI	2,520,508	1,158	4'5	
Mooltan	Mooltan	551,904	67	1'2	
	Jhang	395,296	51	1'2	
	Montgomery	426,529	25	'5	
	Muzaffargarh	338,605	72	2'1	
	TOTAL MOOLTAN	1,712,394	215	1'2	
Derajat	Dera Ismail Khan	441,649	40	'9	
	Dera Ghazi Khan	363,346	78	2'1	
	Bannu	332,577	35	1'0	
	TOTAL DERAJAT	1,137,572	153	1'3	
Peshawar	Peshawar	592,674	90	1'5	
	Hazara	407,975	162	3'9	
	Kohat	181,510	17	'9	
	TOTAL PESHAWAR	1,181,289	269	2'2	
	TOTAL FOR THE PUNJAB	18,842,264*	6,880	3'6	

* Excluding Khair Pass.

Distribution of Lepers, etc., 1881.

District.	Total Population on which the Lepers have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Punjab Feudatory States				
Patiala	1,467,433	581	3'9	
Nabha	261,824	111	4'2	
Kapurthala	252,617	65	2'5	
Jind	249,862	36	1'4	
Faridkot	97,034	20	2'0	
Maler Kotla	71,051	9	1'2	
Kalsia	67,708	38	5'6	
Dujana	23,416	3	1'2	
Pataudi	17,847	...	...	
Loharu	13,754	1	'7	
Bahawalpur	573,494	71	1'2	
Mandi	147,017	232	15'7	
Chamba	115,773	528	45'6	
Nahan	112,371	539	47'9	
Bilaspur	85,546	50	5'7	
Bashahr	64,345	109	16'9	
Nalagarh	53,373	27	5'0	
Suket	52,484	87	16'5	
Keonthal	31,154	120	38'5	
Baghal	29,633	22	10'6	
Jubbal	19,195	78	40'6	
Bhajji	12,106	31	25'6	
Kumharain	9,515	27	28'3	
Mailog	9,169	2	2'1	
Baghat	8,333	22	26'3	
Balsan	5,190	10	19'2	
Kuthar	3,648	3	8'2	

DIVISION.	District.	Total Population on which the Leper-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Nagpur.	Punjab Feudatory States—contd.				
	Dhami	3,322	6	18.0	
	Tarhoch	3,315	14	43.5	
	Sangri	2,593	5	19.2	
	Kunhiar	1,923	...	...	
	Bija	1,158	1	8.6	
	Mangal	1,060	2	18.8	
	Rawai	752	3	39.8	
	Darkoti	590	1	16.9	
	Dadhi	170	...	...	
	Total for the Punjab Feudatory States .	3,861,683	2,854	7.3	
	TOTAL FOR THE PUNJAB, INCLUDING FEUDATORY STATES .				
		22,703,947	9,734	4.2	
	Central Provinces.				
	Nagpur	607,355	849	12.1	
	Bhandara	683,779	450	6.5	
	Chanda	649,145	519	7.9	
	Wardha	387,221	503	12.9	
	Balaghat	340,554	168	4.9	
	TOTAL FOR NAGPUR .	2,758,036	2,489	9.0	

Distribution of Lepers, etc., 1881.

DIVISION.	District.	Total Population on which the Leper-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Jubbulpore	Central Provinces—contd.				
	Jubbulpore	687,233	235	3.4	
	Saugor	554,950	169	2.9	
	Damoh	312,957	65	2.0	
	Seoni	334,733	73	2.1	
	Mandla	301,760	82	2.7	
	TOTAL FOR JUBBULPORE	2,201,633	624	2.8	
	Nerbadda				
	Hoshangabad	488,787	296	6.0	
	Narsinghpur	365,173	150	4.1	
Chhatis-garh	Betul	304,905	114	3.7	
	Chhindwara	372,899	166	4.4	
	Nimar	231,341	204	8.8	
	TOTAL FOR NERBADDA	1,763,105	930	5.2	
	Chhatis-garh				
	Raipur	1,405,171	1,376	9.7	
	Bilaspur	1,017,327	479	4.7	
	Sambalpur	693,499	545	7.8	
	TOTAL FOR CHHATISGARH	3,115,997	2,400	7.7	
	TOTAL FOR THE CENTRAL PROVINCES	9,838,791	6,443	6.5	
Berar.	Berar.				
	Amraoti	575,328	937	16.2	
	Akola	592,792	1,012	17.0	
	Ellichpur	313,805	422	13.4	
	Buldana	439,763	801	18.2	
	Wun	392,102	328	8.3	
	Basim	358,883	248	6.9	
	TOTAL FOR BERAR	2,672,673	3,748	14.0	

DIVISION.	District.	Total Population on which the Leper-ratio have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Madras.	Madras.				
	Ganjam . . .	1,503,301	6.3	4.0	
	Vizagapatam . . .	1,790,468	836	4.7	
	Godavari . . .	1,780,613	1,037	5.8	
	Kistna . . .	1,548,480	626	4.0	
	Nellore . . .	1,230,236	396	3.2	
	Cuddapah . . .	1,121,238	210	1.8	
	Kurnool . . .	709,303	246	3.4	
	Bellary . . .	1,336,696	356	2.6	
	Chinglepu . . .	981,331	984	10.0	
	North Arcot . . .	1,812,514	1,161	6.5	
	South Arcot . . .	1,314,738	1,208	6.6	
	Tanjore . . .	2,130,383	1,072	5.0	
	Trichinopoly . . .	1,215,033	495	4.0	
	Madura . . .	2,168,680	812	3.7	
	Tinnevely . . .	1,699,747	802	4.7	
	Salem . . .	1,599,595	363	2.2	
	Chimbatore . . .	1,657,690	241	1.4	
	Nilgiris . . .	91,034	58	6.3	
	Malabar . . .	2,365,035	1,208	5.1	
	South Canara . . .	959,514	909	9.4	
	Madras City . . .	405,848	435	10.7	
	TOTAL FOR THE BRITISH DISTRICTS OF MADRAS . . .	29,916,629	14,088	4.7	
	Pudukota Territory . . .	302,127	87	2.8	
	TOTAL FOR AGENCY TRACTS OF GANJAM, VIZAGAPATAM, AND GODAVARI . . .	951,875	350	3.6	
	Total for Feudatory States . . .	1,254,002	437	3.4	
	TOTAL FOR THE PRESIDENCY OF MADRAS, INCLUDING FEUDATORY STATES . . .	31,170,631	14,525	4.6	

DIVISION.	District.	Total Population on which the Leper-ratio have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Arakan	British Burma.				
	Akyab . . .	359,706	82	2.2	
	Northern Arakan . . .	14,499	24	16.5	
	Kyaukpada . . .	149,303	37	2.4	
	Sandoway . . .	64,010	26	4.0	
	TOTAL FOR ARAKAN . . .	587,518	169	2.8	
Pegu	Rangoon Town . . .	134,176	81	6.0	
	Hanthawaddy . . .	427,720	409	9.5	
	Tharrawaddy . . .	278,155	166	5.9	
	Prome . . .	322,344	194	6.0	
	TOTAL FOR PEGU . . .	1,162,395	850	7.3	
Irrawaddy.	Thongwa . . .	281,063	325	11.4	
	Bassein . . .	280,119	424	10.8	
	Henzada . . .	318,077	255	8.0	
	Thayetmyo . . .	169,560	110	6.4	
	TOTAL FOR IRRRAWADDY . . .	1,161,119	1,114	9.5	
Tenasserim.	Moulmein Town . . .	53,107	28	5.2	
	Amherst . . .	301,086	157	4.5	
	Tavoy . . .	81,588	14	1.6	
	Mergui . . .	56,550	34	6.0	
	Shwegyin . . .	171,144	1.6	7.9	
	Toangoo . . .	128,848	103	7.9	
	Salween . . .	30,009	4	1.3	
	TOTAL FOR TENASSERIM . . .	825,741	456	5.5	
	TOTAL FOR BRITISH BURMA . . .	3,736,771	2,389	6.9	

DIVISION.	District.	Total Population on which the Leprosy-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Gujarat	Bombay.				
	Allahabad . . .	856,324	76	8	"Leprosy is far more concentrated in the Deccan and Konkan than other infirmities, and is probably retained in greater number than it should be, owing to the inclusion of cases of the false or discolourative disease. In Ratnagiri there is a hospital for this infirmity which may be attended by patients from other parts of the country, and thus raises the local rate. In Sind this disease is scarcely to be found, and it is not unlikely that special care was taken by the enumerators here to exclude cases of the white disease. The operations, too, were under the Local Sanitary Commissioner, who would be likely to keep an extra sharp watch on a matter so interesting to his own departmental study." (Operations and Results, etc., Imperial Census, 1881, Bombay Presidency; by J. A. Balnes, page 95.)
	Kaira . . .	804,800	199	24	
	Panch Mahals . . .	255,479	70	27	
	Broach . . .	325,930	82	25	
	Surat . . .	614,198	383	62	
	TOTAL FOR GUJARAT	2,857,731	810	28	
Konkan	Thana . . .	908,518	749	82	
	Kolaba . . .	381,649	432	113	
	Ratnagiri . . .	997,070	928	93	
	TOTAL FOR KONKAN	2,287,237	2,109	92	
Deccan	Khandesh . . .	1,237,231	1,748	141	
	Nasik . . .	781,266	593	75	
	Ahmednagar . . .	751,228	765	101	
	Poona . . .	900,621	1,088	120	
	Sholapur . . .	582,487	401	68	
	Satara . . .	1,062,350	1,179	110	
	TOTAL FOR DECCAN	5,315,123	5,774	108	
Western Karnatic	Belgaum . . .	864,014	289	33	
	Dharwar . . .	882,907	162	18	
	Kaladgi or Bijapur . . .	638,493	190	29	
	Kanara . . .	421,840	54	12	
	TOTAL FOR WESTERN KARNATIC	2,807,254	695	24	

DIVISION.	District.	Total Population on which the Leprosy-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Sind	Bombay—contd.				
	Kurrachee . . .	478,688	88	18	
	Hyderabad . . .	754,624	91	12	
	Shikarpur . . .	852,986	69	8	
	Thar and Parkar . . .	203,344	12	5	
	Upper Sind Frontier	124,181	17	13	
	TOTAL FOR SIND	2,413,823	277	11	
	City and Island of Bombay . . .	773,196	430	55	
	Aden . . .	34,860	...	...	
	TOTAL FOR BRITISH TERRITORY	15,489,274	10,095	61	
	Bombay Feudatory States.				
	Cutch . . .	512,084	24	4	
	Palanpur . . .	576,478	68	11	
	Mahi Kantha . . .	517,485	55	10	
	Kathiawar . . .	2,343,869	521	22	
	Rewa Kantha . . .	543,452	172	31	
	Cambay . . .	86,074	9	10	
	Narnkot . . .	6,440	1	15	
	Surat Agency . . .	151,132	42	27	
	Jawhar . . .	48,556	6	12	
	Janjira . . .	76,361	84	110	
	Savantvadi . . .	174,433	12	6	
	The Dangs . . .	60,270	50	82	

Division.	District.	Total Population on which the Lepers have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Mysore	Bombay Feudatory States—contd.				
	Satara Jagirs . . .	318,657	214	6.7	
	Akalkot . . .	58,040	28	4.8	
	Kolhapur . . .	800,189	802	10.0	
	Southern Maratha Jagirs . . .	523,753	197	3.7	
	Savner . . .	14,763	2	1.3	
	Total for Feudatory States . . .	6,82,006	2,287	3.2	
	TOTAL FOR THE BOMBAY PRESIDENCY, INCLUDING FEUDATORY STATES . . .	23,391,370	12,382	5.3	
	Mysore.				
	Bangalore . . .	669,139	175	2.6	
	Kolar . . .	461,139	77	1.6	
	Tamkur . . .	413,183	25	.5	
	Mysore . . .	902,566	114	1.2	
	H. ssan . . .	535,806	60	1.1	
	Shimoga . . .	499,728	41	.8	
	Kader . . .	328,327	22	.6	
	Chitaldrog . . .	376,310	19	.5	
	TOTAL FOR MYSORE . . .	4,186,188	533	1.2	
	Coorg.				
Coorg	Coorg . . .	178,302	43	2.4	

Distribution of Lepers in the various Provinces of India according to the Census of 1891.

(a) By Divisions.

NAME OF PROVINCE OR PRESIDENCY.	DIVISION.	Total Population on which the Lepers have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Bengal	Burdwan . . .	7,688,818	12,771	16.6	
	Presidency . . .	8,535,126	3,932	4.6	
	Rajshahye . . .	8,019,187	4,308	5.3	
	Dacca . . .	9,944,127	4,554	4.6	
	Chittagong . . .	4,190,081	1,212	2.8	
	TOTAL FOR BENGAL PROPER . . .	38,277,339	26,777	6.9	
	Patna . . .	15,799,737	6,327	4.0	
	Bhagalpur . . .	8,582,490	4,645	5.4	
	TOTAL FOR BEHAR . . .	24,373,227	10,972	4.5	
	Orissa . . .	3,981,498	4,408	11.0	
	TOTAL FOR ORISSA . . .	3,981,498	4,408	11.0	
	Chota Nagpore . . .	4,638,238	2,073	4.4	
	TOTAL FOR CHOTA NAGPORE . . .	4,638,238	2,073	4.4	
	TOTAL FOR BENGAL . . .	71,270,302	44,230	6.2	
	Total for Feudatory States . . .	3,362,694	2,048	6.0	
	TOTAL FOR BENGAL, INCLUDING FEUDATORY STATES . . .	74,632,996	46,278	6.2	

NAME OF PROVINCE OR PRESIDENCY.	DIVISION.	Total Population on which the Leper-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Assam	Assam . . .	5,435,243	6,727	12.3	
North-Western Provinces and Oudh.	Meerut . . .	5,326,833	1,317	2.4	
	Agra . . .	4,767,759	797	1.6	
	Rohilkund . . .	5,343,674	2,131	3.9	
	Allahabad . . .	5,755,138	1,922	3.3	
	Benares . . .	5,368,774	1,553	2.8	
	Gorakhpur . . .	6,508,526	2,210	3.3	
	Kumaun . . .	1,131,567	1,838	15.5	
	TOTAL FOR NORTH-WESTERN PROVINCES . . .	34,252,271	11,768	3.4	
	Lucknow . . .	5,856,559	2,307	3.9	
	Fyzabad . . .	6,794,272	2,996	4.4	
	TOTAL FOR OUDH . . .	12,650,831	5,303	4.1	
	TOTAL FOR NORTH-WESTERN PROVINCES AND OUDH . . .	46,903,102	17,071	3.6	
	Total for Feudatory States . . .	792,491	370	4.7	
	TOTAL FOR NORTH-WESTERN PROVINCES AND OUDH, INCLUDING FEUDATORY STATES . . .	47,695,593	17,450	3.6	

NAME OF PROVINCE OR PRESIDENCY.	DIVISION.	Total population on which the Leper-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Punjab and British Baluchistan.	Delhi . . .	1,091,336	350	1.7	
	Hissar . . .	1,366,481	201	1.4	
	Umballa . . .	1,726,791	590	3.4	
	Jullundur . . .	2,682,273	1,370	5.1	
	Amritsar . . .	3,056,466	482	1.5	
	Lahore . . .	2,652,224	229	.8	
	Rawalpindi . . .	2,750,713	696	2.5	
	Mooltan . . .	1,948,891	127	.6	
	Derajat . . .	1,262,508	78	.6	
	Peshawar . . .	1,423,231	228	1.6	
	Beluch Tribes . . .	5,934	—	—	
	TOTAL FOR THE PUNJAB . . .	20,866,647	4,351	2.0	
	Quetta . . .	27,270	2	.7	
Central Provinces.	TOTAL FOR THE PUNJAB AND BRITISH BALUCHISTAN . . .	20,894,117	4,353	2.0	
	Total for Feudatory States . . .	4,163,280	1,020	4.5	
	TOTAL FOR THE PUNJAB AND BRITISH BALUCHISTAN, INCLUDING FEUDATORY STATES . . .	25,157,397	6,273	2.4	
		...	...	...	* Returns not received.
Berar	TOTAL FOR THE CENTRAL PROVINCES . . .	...	...	...	
	Berar . . .	2,897,040	3,698	12.7	
GRAND TOTAL FOR THE PRESIDENCY OF BENGAL.	BRITISH TERRITORY† . . .	147,399,804	76,079	5.1	† Incomplete.
	Feudatory States‡ . . .	8,418,465	4,347	5.1	‡ Incomplete.
	TOTAL§ . . .	155,818,269	80,426	5.1	§ Incomplete.

NAME OF PROVINCE OR PRESIDENCY.	DIVISION.	Total Population in which the Leper-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Madras	Ganjam . . .	1,580,477	817	5.1	
	Vizagapatam . . .	1,943,211	964	4.9	
	Godavari . . .	1,951,645	905	4.6	
	Kistna . . .	1,855,582	465	2.6	
	Nellore . . .	1,463,736	420	2.8	
	Cuddapah . . .	1,372,072	180	1.4	
	Kurnool . . .	817,811	171	2.0	
	Anantapur . . .	708,549	88	1.2	
	Bellary . . .	900,126	259	2.8	
	Chingleput . . .	1,136,928	689	6.0	
	North Arcot . . .	2,180,487	1,136	5.2	
	South Arcot . . .	2,162,851	1,033	4.7	
	Tanjore . . .	2,228,114	710	3.1	
	Trichinopoly . . .	1,372,717	322	2.3	
	Madura . . .	2,608,401	564	2.1	
	Tinnevely . . .	1,916,093	411	2.1	
	Salem . . .	1,962,591	236	1.2	
	Coimbatore . . .	2,004,839	101	.5	
	Nilgiris . . .	99,797	40	4.0	
	Malabar . . .	2,652,565	1,472	4.4	
	South Canara . . .	1,056,081	916	8.6	
	Madras City . . .	452,518	347	7.6	
	TOTAL FOR THE BRITISH DISTRICTS OF MADRAS . . .	34,336,196	18,957	3.4	
	Total for Feudatory States . . .	4,135,085	1,804	4.3	Excluding Vizagapatam Agency Tracts, the returns for which arrived too late for publication.
	TOTAL FOR THE PRESIDENCY OF MADRAS INCLUDING FEUDATORY STATES . . .	38,471,281	20,761	3.5	

NAME OF PROVINCE OR PRESIDENCY.	DIVISION.	Total Population in which the Leper-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
British Burma.	Arakan . . .	671,809	206	3.0	
	Pegu . . .	1,456,489	1,039	7.1	
	Irrawaddy . . .	1,552,166	1,351	8.7	
	Tenasserim . . .	978,073	364	3.7	
	TOTAL FOR LOWER BURMA . . .	4,658,627	2,960	6.3	
	Northern . . .	649,035	769	11.8	
	Central . . .	648,403	934	14.4	
	Southern . . .	1,098,829	1,323	12.0	
	Eastern . . .	550,283	478	8.6	
	TOTAL FOR UPPER BURMA . . .	2,846,550	3,504	11.8	
Bombay.	TOTAL FOR BRITISH BURMA . . .	7,605,177	6,464	8.4	
	Gujarat . . .	3,098,197	608	1.9	
	Konkan . . .	2,520,378	2,106	8.3	
	Deccan . . .	6,237,566	5,992	9.6	
	Western Karnatic . . .	3,307,265	902	2.7	
	Sind . . .	2,871,774	209	.7	
	City and Island of Bombay . . .	821,754	369	4.4	
	TOTAL FOR BRITISH TERRITORY . . .	18,857,044 (18,901,123)	10,186 (10,187)	5.4* (5.3)†	* Exclusive of Aden. † Inclusive of Aden.
	Total for Feudatory States . . .	8,050,208	2,554	3.1	
	TOTAL FOR THE BOMBAY PRESIDENCY, INCLUDING FEUDATORY STATES . . .	26,916,342 (26,960,421)	12,740 (12,741)	4.7† (4.7)‡	† Exclusive of Aden. ‡ Inclusive of Aden.
Ajmere-Merwara.	Ajmere-Merwara . . .	542,358	27	.4	
Mysore	Mysore ‡ . . .	4,843,523 (4,943,604)	802 (814)	1.6 (1.6)	‡ Exclusive of Bangalore City (British). The figures in brackets give the numbers and ratios inclusive of Bangalore.
Coorg	Coorg . . .	173,055	23	1.3	

NAME OF PROVINCE OR PRESIDENCY.	DIVISION.	Total Population on which the Leper-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
The Nizam's Dominions.	Hyderabad . . .	415,039	105	2.5	
	Telingana . . .	4,641,113	1,053	2.2	
	Marathwara . . .	4,692,571	1,346	2.8	
	Kanara (Karnatic) . . .	1,781,727	473	2.6	
	Railways . . .	6,590	—	—	
	TOTAL FOR THE NIZAM'S DOMINIONS . . .	11,537,040	2,977	2.5	
Rajputana Agency.	Meywar . . .	2,055,542	153	7	
	Jodhpore . . .	2,821,594	594	2.1	
	Bikaner . . .	831,955	259	3.1	
	Jeypore . . .	2,961,152	163	5	
	East State Agency . . .	1,075,619	182	1.6	
	Ulwar . . .	767,786	79	1.0	
	Jhalawar . . .	343,601	92	2.6	
	Harwar and Tonk . . .	739,392	123	1.6	
	Kotah . . .	526,267	63	1.1	
	Cantonments . . .	2,749	—	—	
	TOTAL FOR RAJPUTANA AGENCY . . .	12,126,555	1,768	1.4	
Central India Agency.	Central India Agency . . .	9,451,376	80	0.8	* Incomplete.
Railways and Cantonments, etc.†	Aden Settlement . . .	44,079	1	2	† So far as they have not been included in the above figures. Incomplete.
	Andaman Isles . . .	15,609	1	6	
	Bangalore . . .	100,081	12	1.1	
	Central India . . .	99,636	12	1.2	
	TOTAL FOR RAILWAYS AND CANTONMENTS . . .	259,455	26	1.0	
	Grand Total for India, British Territory‡ . . .	209,000,034	104,749	5.0	‡ Incomplete.
	Grand Total for India, Feudatory States§ . . .	58,744,497	14,295	2.4	§ Incomplete.
	Grand Total for India, including Feudatory States . . .	267,744,531	119,044	4.4	Incomplete.

Distribution of Lepers in the various Provinces of India according to the Census of 1891—contd.

(b) By District

DIVISION.	DISTRICT.	Total Population on which the Leper-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Burdwan.	Rengai.				
	Burdwan . . .	1,391,880	3,002	21.5	
	Bankoora . . .	1,069,668	3,893	36.3	
	Beerbhoom . . .	797,813	2,810	35.2	
	Midnapore . . .	2,631,516	2,094	7.9	
	Hoochly . . .	1,076,710	750	6.9	
	Howrah . . .	721,211	222	3.0	
	TOTAL FOR BURDWAN . . .	7,688,818	12,771	16.6	
	24-Pergunnahs . . .	1,892,033	658	3.4	
	Calcutta . . .	681,560	173	2.5	
Presidency.	Naddea . . .	1,644,108	1,165	7.0	
	Jessore . . .	1,888,827	752	3.9	
	Khoolna . . .	1,177,652	155	1.3	
	Moershed d . . .	1,250,946	1,029	8.2	
	TOTAL FOR PRESIDENCY . . .	8,535,126	3,932	4.6	
	Dinagepore . . .	1,555,835	719	4.6	
	Rajshahye . . .	1,313,336	314	2.3	
Rajshahye.	Rungpore . . .	2,065,464	1,415	6.8	
	Bogra . . .	817,494	435	5.3	
	Pubna . . .	1,362,392	572	4.1	
	Darjeeling . . .	223,314	169	7.5	
	Jalpaiguri . . .	681,352	681	9.9	
	TOTAL FOR RAJSHAHYE . . .	8,019,187	4,308	5.3	
Dacca.	Dacca . . .	2,420,656	859	3.5	
	Furreedpore . . .	1,797,320	497	2.7	
	Backergunge . . .	2,153,965	316	1.4	
	Mymensingh . . .	3,472,186	2,882	8.3	
	TOTAL FOR DACC A . . .	9,844,127	4,554	4.6	

Division.	District.	Total Population on which the Leper-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Chittagong.	Bengal—contd.				
	Chittagong . . .	1,290,167	304	2'3	
	Noakholly . . .	1,009,693	148	1'4	
	Tipperah . . .	1,783,935	696	3'8	
	Chittagong Hill Tracts . . .	107,286	64	5'9	
	TOTAL FOR CHITTAGONG . . .	4,190,281	1,212	2'8	
Patna.	TOTAL FOR BENGAL PROPER . . .	38,277,339	26,777	6'9	
	Patna . . .	1,769,004	692	3'9	
	Gya . . .	2,138,331	1,621	7'5	
	Shahabad . . .	2,043,060	915	4'4	
	Mozufferpore . . .	2,711,445	751	2'7	
	Durbhanga . . .	2,801,955	660	2'3	
	Sarun . . .	2,467,477	1,095	4'4	
	Chumparun . . .	1,859,165	593	3'1	
	TOTAL FOR PATNA . . .	15,790,737	6,327	4'0	
Bhagalpur	Monghyr . . .	2,036,021	1,313	6'4	
	Bhagalpur . . .	2,032,696	932	4'5	
	Purneah . . .	1,944,658	1,204	6'1	
	Maldah . . .	814,919	497	6'0	
	Sonthal Pergunnahs. . .	1,754,196	699	3'9	
Orissa	TOTAL FOR BHAGALPUR . . .	8,382,490	4,645	5'4	
	TOTAL FOR BEHAR . . .	24,373,227	10,972	4'5	
	Cuttack . . .	1,938,132	1,683	8'6	
	Pooree . . .	944,998	1,473	15'5	
	Balasore . . .	991,625	1,201	12'0	
	Angul . . .	103,743	51	4'9	
	TOTAL FOR ORISSA . . .	3,981,498	4,408	11'0	

Division.	District.	Total Population on which the Leper-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Chota Nagpore.	Bengal—concl'd.				
	Hazaribagh . . .	1,164,321	195	1'6	
	Lohardugga . . .	1,735,101	208	1'1	
	Singbhoom . . .	545,488	195	3'5	
	Manbhoom . . .	1,193,328	1,475	12'3	
	TOTAL FOR CHOTA NAGPORE . . .	4,638,238	2,073	4'4	
Feudatory States.	TOTAL FOR BENGAL . . .	71,270,302	44,230	6'2	
	Cooch Behar . . .	578,868	787	13'5	
	Hill Tipperah . . .	137,442	70	5'0	
	Tributary States, Orissa . . .	1,763,025	1,031	5'8	
	Tributary States, Chota Nagpore . . .	883,359	160	1'8	
	Total for Feudatory States . . .	3,362,694	2,048	6'2	
Surma Valley.	TOTAL FOR BENGAL, INCLUDING FEUDATORY STATES . . .	74,632,996	46,278	6'2	
	Assam.				
	Cachar (Plains) . . .	367,542	427	11'6	
Brahmaputra Valley.	Sylhet . . .	2,154,593	2,927	13'5	
	TOTAL FOR SURMA VALLEY . . .	2,522,135	3,354	13'2	
Brahmaputra Valley.	Goalpara . . .	452,304	874	19'3	
	Kamrup . . .	634,249	425	6'7	
	Darrang . . .	307,761	294	9'5	
	Nowgong . . .	344,141	323	9'3	
	Sibsagar . . .	457,274	720	15'7	
	Lakhimpur . . .	254,053	354	13'9	
	TOTAL FOR BRAHMAPUTRA VALLEY . . .	2,449,782	2,991	12'2	

REPORT OF THE LEPROSY COMMISSION:

DIVISION.	District.	Total Population on which the Lepers-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Hill Tracts.	Assam—contd.				
	Khasi and Jaintia Hills	197,904	94	4.7	
	Cachar Hills	18,941	25	13.1	
	Naga Hills	122,867	126	10.2	
	Garo Hills	121,570	137	11.2	
	TOTAL FOR HILL TRACTS	461,282	382	8.2	
	North Lushai	2,044	NIL.	—	
	TOTAL FOR THE PROVINCE OF ASSAM	5,435,243	6,727	12.3	
Meerut	North-Western Provinces.				
	Dehra Dun	168,135	345	20.5	
	Saharanpur	1,001,280	174	1.7	
	Muzaffarnagar	772,874	137	1.7	
	Meerut	1,391,458	290	2.0	
	Bulandshahr	949,914	241	2.5	
	Aligarh	1,043,172	130	1.2	
	TOTAL FOR MEERUT	5,326,833	1,317	2.4	
Agra	Mottra	713,421	153	2.1	
	Agra	1,003,796	207	2.0	
	Farrukhabad	858,087	113	1.3	
	Mainpuri	762,163	98	1.2	
	Etawah	727,629	64	.8	
	Etah	702,063	162	2.3	
	TOTAL FOR AGRA	4,767,759	797	1.6	

Distribution of Lepers, etc., 1891.

DIVISION.	District.	Total Population on which the Lepers-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Rohilkund	North-Western Provinces—contd.				
	Bareilly	1,040,691	342	3.2	
	Bijnor	794,070	280	3.5	
	Budaun	925,598	279	3.0	
	Moradabad	1,179,398	685	5.8	
	Shahjahanpur	918,551	426	4.6	
	Pilibhit	485,366	119	2.4	
	TOTAL FOR ROHILKUND	5,343,674	2,131	3.9	
Allahabad	Cawnpore	1,209,695	237	1.9	
	Fatehpur	699,157	94	1.3	
	Banda	705,832	449	6.3	
	Hamirpur	513,720	350	6.8	
	Allahabad	1,548,737	355	2.2	
	Jhansi	407,436	168	4.1	
	Jalaun	396,361	137	3.4	
	Lalitpur	274,200	132	4.8	
	TOTAL FOR ALLAHABAD	5,755,138	1,922	3.3	
Benares	Benares	921,943	314	3.4	
	Mirzapur	1,161,508	274	2.3	
	Jaunpur	1,264,949	223	1.7	
	Ghazipur	1,077,909	409	3.7	
	Balkia	942,465	333	3.5	
	TOTAL FOR BENARES	5,368,774	1,553	2.8	
Gorakhpur.	Gorakhpur	2,994,057	1,011	3.3	
	Basti	1,785,841	638	3.5	
	Azamgarh	1,728,625	561	3.2	
	TOTAL FOR GORAKHPUR	6,508,526	2,210	3.3	

REPORT OF THE LEPROSY COMMISSION:

Division.	District.	Total Population on which the Leper-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Kumaon	North-Western Provinces - <i>contd.</i>				
	Kumaon	563,181	1,113	19.7	
	Garhwal	497,818	692	16.9	
	Tarai	210,568	33	1.5	
	TOTAL FOR KUMAON	1,181,567	1,838	15.5	
Lucknow	Oudh.				
	Lucknow	774,163	360	4.6	
	Unao	953,636	310	3.2	
	Rae Bareilly	1,036,521	494	4.7	
	Sitapur	1,075,413	605	5.6	
Fyzabad	Hardoi	1,113,211	290	2.6	
	Kheri	903,615	239	2.6	
	TOTAL FOR LUCKNOW	5,856,559	2,307	3.9	
	Fyzabad	1,216,059	753	6.1	
	Gonda	1,459,229	349	2.3	
	Baraich	1,000,432	303	3.0	
	Sultanpur	1,075,851	527	4.8	
	Partabgarh	910,895	216	2.3	
	Bara Banki	1,130,956	848	7.4	
	TOTAL FOR FYZABAD	6,794,372	2,996	4.4	
Total for Oudh		12,650,831	5,303	4.1	
Total for North Western Provinces and Oudh		46,503,102	17,071	3.6	

Distribution of Lepers, etc., 1891.

Division.	District.	Total Population on which the Leper-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Feudatory States	Oudh-- <i>contd.</i>				
	Rampur State.	551,249	69	1.2	
	Tehri Garhwal	241,242	310	12.8	
	TOTAL FOR FEUDATORY STATES	792,491	379	4.7	
	TOTAL FOR NORTH-WESTERN PROVINCES AND OUDH, INCLUDING FEUDATORY STATES	47,695,593	17,450	3.6	
Delhi	Punjab and British Beluchistan.				
	Delhi	638,689	81	1.2	
	Gurgaon.	668,929	174	2.6	
	Karnal	683,718	55	1.3	
	TOTAL FOR DELHI	1,991,336	350	1.7	
Hissar	Hissar	776,006	132	1.7	
	Rohatak	590,475	69	1.1	
	TOTAL FOR HISSAR	1,366,481	201	1.4	
Umballa	Umballa	1,033,427	339	3.2	
	Ludhiana	648,722	122	1.8	
	Simla	44,642	129	28.8	
	TOTAL FOR UMBALLA	1,726,791	590	3.4	
Jullundur.	Jullundur	907,583	209	2.3	
	Hoshiarpur	1,011,659	333	3.2	
	Kangra	763,030	828	10.8	
	TOTAL FOR JULLUNDUR	2,682,272	1,370	5.1	

DIVISION.	District.	Total Population on which the Lepers have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Amritsar	Punjab and British Baluchistan—cont'd.				
	Amritsar . . .	902,697	151	1'5	
	Gurdaspur . . .	943,922	164	1'7	
	Sialkot . . .	1,119,847	167	1'4	
	TOTAL FOR AMRITSAR . . .	3,056,466	482	1'5	
Lahore	Lahore . . .	1,075,379	52	'4	
	Gujranwala . . .	690,169	40	'5	
	Ferozepore . . .	805,676	137	1'5	
	TOTAL FOR LAHORE . . .	2,652,224	229	'8	
Rawalpindi	Rawalpindi . . .	837,194	325	3'5	
	Jhelum . . .	609,956	141	2'3	
	Gujrat . . .	763,875	192	2'5	
	Shahpur . . .	433,588	38	'7	
	TOTAL FOR RAWALPINDI . . .	2,750,713	696	2'5	
Mooltan	Mooltan . . .	611,131	30	'4	
	Jhang . . .	435,841	23	'5	
	Montgomery . . .	499,521	31	'6	
	Muzaffargarh . . .	581,093	43	1'1	
	TOTAL FOR MOOLTAN . . .	1,938,891	127	'6	
Derajat	Dera Ismail Khan . . .	486,201	16	'3	
	Dera Ghazi Khan . . .	404,031	30	'7	
	Bannu . . .	372,276	32	'8	
	TOTAL FOR DERAJAT . . .	1,262,508	78	'6	

DIVISION.	District.	Total Population on which the Lepers have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Peshawar	Punjab and British Beluchistan—cont'd.				
	Peshawar . . .	703,768	59	'8	
	Hazara . . .	516,283	156	3'0	
	Kohat . . .	203,175	13	'6	
	TOTAL FOR PESHAWAR . . .	1,423,231	228	1'6	
British Baluchistan.	Biluch Tribes . . .	5,934	NIL	—	
	Quetta . . .	27,270	2	'7	
	TOTAL FOR THE PUNJAB AND BRITISH BALUCHISTAN . . .	20,894,117	4,353	2'0	
Punjab Feudatory States.	Punjab Feudatory States.				
	Patiala . . .	1,583,521	186	1'1	
	Nabha . . .	232,756	28	'9	
	Kapurthala . . .	299,690	89	2'9	
	Jind . . .	284,560	21	'7	
	Faridkot . . .	115,040	13	1'1	
	Malir Kotla . . .	75,755	24	3'1	
	Kalsia . . .	68,633	14	2'0	
	Dujana . . .	26,450	5	1'8	
	Pataudi . . .	19,002	NIL	—	
	Loharu . . .	20,139	3	1'4	
	Bahawalpur . . .	630,042	30	'4	
	Mandi . . .	166,923	250	14'9	
	Chamba . . .	124,032	422	34'0	
	Nahan . . .	124,134	264	21'2	
	Bilaspur . . .	91,760	27	2'9	
	Bashahr . . .	75,727	101	13'3	
	Nalagarh . . .	54,032	5	'9	
	Suket . . .	52,403	22	4'1	
	Keonthal . . .	37,320	179	47'9	

REPORT OF THE LEPROSY COMMISSION:

DIVISION.	District.	Total Population on which the Leper-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Punjab Feudatory States.	Punjab Feudatory States—contd.				
	Baghal . . .	24,545	14	5.7	
	Jubbil . . .	21,412	50	23.3	
	Bhajji . . .	12,205	51	41.7	
	Kamharsain . . .	10,416	40	38.4	
	Mallig . . .	9,329	9	9.6	
	Baghat . . .	8,668	16	18.4	
	Balsan . . .	5,496	27	49.1	
	Kuthar . . .	3,947	6	15.2	
	Dhami . . .	3,985	6	15.0	
	Tarhoch . . .	3,938	11	27.9	
	Sangri . . .	2,606	1	3.8	
	Kunihar . . .	1,957	2	10.2	
	Bija . . .	1,171	Nil.	—	
	Mangal* . . .	1,091	4	36.6	
	Darkoti . . .	595	Nil.	—	* Rawal and Dachs have been included in the statistical returns for Simla.
	Total for the Punjab Feudatory States . .	4,263,280	1,920	4.5	
	TOTAL FOR THE PUNJAB AND BRITISH BELUCHISTAN, INCLUDING FEUDATORY STATES . .	25,157,397	6,273	2.4	
Nagpur	Central Provinces.†				
	Nagpur . . .	...	...	...	
	Bhandara . . .	...	...	...	
	Chanda . . .	...	...	...	
	Wardha . . .	...	...	...	
	Balaghat . . .	...	...	...	
	TOTAL FOR NAGPUR	...	...	...	

† Returns not received.

Distribution of Lepers, etc., 1891.

DIVISION.	District.	Total Population on which the Leper-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Jubbulpore.	Central Provinces—contd.				
	Jubbulpore . . .	...	...	...	
	Saugor . . .	...	...	...	
	Damoh . . .	...	...	...	
	Seoni . . .	...	...	...	
	Mandla . . .	...	...	...	
	TOTAL FOR JUBBULPORE . . .	...	...	...	
Narbada.	Hoshangabad . . .	...	...	...	
	Narsinghpur . . .	...	...	...	
	Betul . . .	...	...	...	
	Chhindwara . . .	...	...	...	
	Nimar . . .	...	...	...	
	TOTAL FOR NARBADA	...	...	...	
Chhattisgarh.	Raipur . . .	...	...	...	
	Bilaspur . . .	...	...	...	
	Sambalpur . . .	...	...	...	
	TOTAL FOR CHATTISGARH . . .	...	...	...	
Berar.	Berar.				
	Amraoti . . .	655,645	932	14.2	
	Akola . . .	574,732	910	15.8	
	Ellichpur . . .	315,798	524	16.5	
	Buldana . . .	481,021	779	16.1	
	Wun . . .	471,613	377	7.9	
	Basim . . .	398,181	176	4.4	
	TOTAL FOR BERAR . . .	2,897,040	3,698	12.7	

Division.	District.	Total Population on which the Leper-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Madras	Madras.				
	Ganjam . . .	1,589,477	817	5'1	
	Vizagapatam . . .	1,913,211	964	4'9	
	Godavari . . .	1,031,925	906	4'6	
	Kistna . . .	1,855,582	485	2'6	
	Nellore . . .	1,453,736	420	2'8	
	Cuddapah . . .	1,274,072	180	1'4	
	Kurnool . . .	817,811	171	2'0	
	Anantapur . . .	708,549	88	1'2	
	Bellary . . .	900,126	259	2'8	
	Chingleput . . .	1,136,928	689	6'0	
	North Arcot . . .	2,180,487	1,136	5'2	
	South Arcot . . .	2,162,851	1,033	4'7	
	Tanjore . . .	2,228,114	710	3'1	
	Trichinopoly . . .	1,372,717	322	2'3	
	Madura . . .	2,608,404	564	2'1	
	Tinnevely . . .	1,916,095	411	2'1	
	Salem . . .	1,662,591	236	1'2	
	Coimbatore . . .	2,001,839	101	'5	
	Nilgiris . . .	99,797	40	4'0	
	Malabar . . .	2,652,565	1,172	4'4	
	South Canara . . .	1,056,081	916	8'6	
	Madras City . . .	453,518	347	7'6	
Madras Fendatory States.	TOTAL FOR THE BRITISH DISTRICTS OF MADRAS . . .	34,336,196	11,967	3'4	
	Madras Fendatory States.				
	Travancore . . .	2,557,736	968	3'7	
	Cochin . . .	722,906	350	4'8	
	Putukota . . .	373,096	101	2'7	
	Banganapalle . . .	35,496	18	5'0	
	Sandur . . .	11,388	2	1'7	
	Ganjam Agency . . .	307,326	279	9'0	
	Godavari " . . .	127,137	86	6'9	
	Total for Fendatory States . . .	4,135,085	1,804	4'3	
	TOTAL FOR MADRAS PRESIDENCY, IN- CLUDING FEN- DATORY STATES . . .	38,471,281	13,771	3'5	
					* Returns for Vizagapa- tam Agency not received.

Division.	District.	Total Population on which the Leper-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Arakan	Lower Burma.				
	Akyab . . .	416,305	107	2'5	
	Northern Arakan . . .	14,628	41	28'0	
	Kyaukpyu . . .	163,832	50	3'0	
	Sandoway . . .	77,134	8	1'0	
	TOTAL FOR ARAKAN . . .	671,899	206	3'0	
Pegu	Pegu . . .	301,420	308	10'2	
	Rangoon Town . . .	180,324	67	3'7	
	Hanthawaddy . . .	267,039	230	8'6	
	Tharrawaddy . . .	347,454	228	6'5	
	Prome . . .	360,252	206	5'7	
	TOTAL FOR PEGU . . .	1,456,489	1,039	7'1	
Irrawad- dy.	Thongwa . . .	446,076	462	10'3	
	Bassein . . .	475,002	403	8'4	
	Henzada . . .	380,927	322	8'4	
	Thayetmyo . . .	253,161	164	6'5	
	TOTAL FOR IRR- WADDY . . .	1,552,166	1,351	8'7	
Tenasser- im.	Amherst . . .	417,312	107	2'5	
	Tavoy . . .	94,921	16	1'6	
	Mergui . . .	73,748	35	4'7	
	Shwegyin . . .	108,521	97	4'8	
	Toungoo . . .	162,132	97	5'9	
	Salween . . .	51,439	12	3'8	
	TOTAL FOR TENAS- SERIM . . .	978,073	364	3'7	
	TOTAL FOR LOWER BURMA . . .	4,658,627	2,960	6'3	

DIVISION.	District.	Total Population on which the Leper-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Northern	Upper Burma.				
	Mandalay . . .	374,060	598	15.9	
	Bhamo . . .	54,257	20	3.6	
	Katha . . .	59,329	30	5.0	
	Shwebo . . .	135,255	108	7.9	
	Ruby Mines . . .	26,134	13	4.9	
	TOTAL FOR NORTHERN	649,035	769	11.8	
Central	Ye-u . . .	92,549	93	10.0	
	Sagaing . . .	248,207	424	17.0	
	Lower Chindwin . . .	232,245	358	15.4	
	Upper Chindwin . . .	75,402	59	7.8	
	TOTAL FOR CENTRAL	648,403	934	14.4	
Southern	Myingyan . . .	351,411	533	15.1	
	Pakkoku . . .	303,753	271	8.9	
	Minbu . . .	224,475	270	12.0	
	Magwe . . .	219,190	249	11.3	
	TOTAL FOR SOUTHERN	1,098,829	1,323	12.0	
Eastern	Kyaukse . . .	126,622	111	8.7	
	Meiktila . . .	206,650	230	11.1	
	Yamethin . . .	160,662	99	6.1	
	Pyinmana . . .	56,349	38	6.7	
	TOTAL FOR EASTERN	550,283	478	8.6	
	TOTAL FOR UPPER BURMA	2,946,550	3,504	11.8	
	TOTAL FOR BRITISH BURMA	7,605,177	6,464	8.4	

DIVISION.	District.	Total Population on which the Leper-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Gujarat	Bombay.				
	Ahmedabad . . .	921,712	96	1.0	
	Kaira . . .	871,589	120	1.3	
	Panch Mahals . . .	313,417	73	2.3	
	Broach . . .	341,490	77	2.2	
	Surat . . .	649,989	242	3.7	
	TOTAL FOR GUJARAT	3,098,197	608	1.9	
Konkan.	Thana . . .	904,868	559	6.1	
	Kolaba . . .	509,584	464	9.1	
	Ratnagiri . . .	1,105,926	1,083	9.7	
	TOTAL FOR KONKAN	2,520,378	2,106	8.3	
Deccan	Khandesh . . .	1,460,851	1,609	11.6	
	Nasik . . .	843,582	425	5.0	
	Ahmednagar . . .	888,755	605	7.8	
	Poona . . .	1,067,800	1,078	10.0	
	Sholapur . . .	750,689	607	8.0	
	Satara . . .	1,225,989	1,488	12.1	
	TOTAL FOR DECCAN	6,237,666	5,992	9.6	
Western Karnatic	Belgaum . . .	1,013,261	338	3.3	
	Dharwar . . .	1,051,314	214	2.0	
	Kaladgi or Bijapur . . .	796,339	331	4.1	
	Kanara . . .	446,351	19	.4	
	TOTAL FOR WESTERN KARNATIC	3,307,265	902	2.7	

REPORT OF THE LEPROSY COMMISSION:

DIVISION.	District.	Total Population on which the Leper-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Sind	Bombay—contd.				
	Kutch . . .	564,880	55	'9	
	Hyderabad . . .	918,646	58	'6	
	Shikarpur . . .	915,497	74	'8	
	Thar and Parkar . . .	298,203	7	'2	
	Upper Sind Frontier	174,548	15	'8	
	TOTAL FOR SIND	2,871,774	209	'7	
Bombay Feudatory States.	City and Island of Bombay . . .	821,764	369	4'4	
	TOTAL FOR BOMBAY PRESIDENCY (BRITISH TERRITORY*)	18,857,044 (18,901,123)	10,186 (10,167)	5'4 (5'3)	* Exclusive of Aden. The figures in brackets denote the numbers and ratios inclusive of Aden.
	Bombay Feudatory States.				
	Cutch . . .	558,415	27	'4	
	Palanpur . . .	645,526	54	'8	
	Mahi Kantha . . .	581,568	65	1'1	
	Kathiawar . . .	2,752,404	426	1'5	
	Rewa Kantha . . .	733,506	319	4'3	
	Cambay . . .	89,722	8	'8	
	Narukot . . .	...	...	...	
	Surat Agency . . .	181,203	51	2'8	
	Jawhar . . .	52,831	36	6'8	
	Janjira . . .	81,780	79	9'6	
	Savantvadi . . .	192,948	35	1'8	
	The Dangs . . .	32,920	3	'9	
	Surgana . . .	12,368	6	4'8	
	Satara Jagirs . . .	131,529	76	5'7	
	Bhor . . .	155,669	143	9'1	
	Akalkot . . .	75,774	23	3'0	
	Jath . . .	79,786	14	1'7	
	Kolhapur . . .	913,131	956	10'4	
	Southern Maratha Jagirs . . .	639,270	227	3'5	
	Khairpur . . .	131,937	6	'4	
	Sayanur . . .	16,976	Nil.	—	
	Total for Feudatory States	8,059,293	2,554	3'1	
	TOTAL FOR BOMBAY PRESIDENCY, INCLUDING FEUDATORY STATES	26,916,342 (26,950,421)	12,740 (12,741)	4'7* (4'7)†	* Exclusive of Aden. † Inclusive of Aden.

DIVISION.	District.	Total Population on which the Leper-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Ajmere-Merwara	Ajmere-Merwara.				
	Ajmere . . .	422,359	11	'2	
	Merwara . . .	119,999	16	1'3	
	TOTAL FOR AJMERE-MERWARA	542,358	27	'4	
Mysore	Mysore.				
	Bangalore* . . .	702,913	239	3'4	* Exclusive of Bangalore City (British portion).
	Kolar . . .	591,030	185	3'1	
	Tumkur . . .	580,786	44	'7	
	Mysore . . .	1,181,814	149	1'2	
	Hassan . . .	514,952	69	1'3	
	Shimoga . . .	527,981	55	1'0	
	Kadur . . .	330,063	17	'5	
	Chitaldroog . . .	413,984	44	1'0	
	TOTAL FOR MYSORE†	4,843,523 (4,943,604)	862 (814)	1'6 (1'6)	† The figures in brackets denote the numbers and ratios inclusive of Bangalore.
Coorg	Coorg				
	Coorg . . .	173,055	23	1'3	
	TOTAL FOR MYSORE AND COORG	5,016,578 (5,116,639)†	825 (837)	1'6 (1'6)	† Figures in brackets inclusive of Bangalore City.
	The Nizam's Dominions.				
Hyderabad	Hyderabad City . . .	124,057	29	2'3	
	Suburbs and Secunderabad . . .	290,982	76	2'6	
	TOTAL FOR HYDERABAD	415,039	105	2'5	

REPORT OF THE LEPROSY COMMISSION:

DIVISION.	District.	Total Population on which the Leper-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Telin-gana.	The Nizam's Dominions—contd.				
	Atraf-i-Balda . . .	389,784	105	2'6	
	Mahbubnagar (Nagad, Karnul) . . .	674,649	106	1'5	
	Nalgonda . . .	624,617	91	1'4	
	Worangal (Khamam) . . .	853,129	157	1'8	
	Yelgandal . . .	1,094,601	200	1'8	
	Indur . . .	639,598	171	2'6	
	Medak . . .	364,735	223	6'1	
	TOTAL FOR TELINGANA . . .	4,641,113	1,053	2'2	
Maharath-wara.	Aurangabad . . .	828,975	306	3'6	
	Bid . . .	642,722	236	3'6	
	Nanded . . .	632,529	92	1'4	
	Naldurg . . .	649,272	330	5'0	
	Bidar . . .	901,984	213	2'3	
	Parbhani . . .	805,335	112	1'3	
	Sirpur Tandur . . .	231,754	57	2'4	
	TOTAL FOR MAHARATHWARA . . .	4,692,571	1,346	2'8	
Kanara or Karnatic.	Gulbarga . . .	649,258	161	2'4	
	Raichur . . .	512,455	119	2'3	
	Lingsugur . . .	620,014	193	3'1	
	TOTAL FOR KANARA OR KARNATIC . . .	1,781,727	473	2'6	
	RAILWAYS . . .	6,590	Nil.	—	
	TOTAL FOR THE NIZAM'S DOMINIONS . . .	11,537,040	2,977	2'5	

Distribution of Lepers, etc., 1891.

DIVISION.	District.	Total Population on which the Leper-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Meywar Residency	Rajputana.				
	Meywar . . .	1,709,781	78	4	
	Banswara . . .	180,268	2	1	
	Kusalgarh . . .	5,775	2	3'4	
	Dungarpur . . .	98,448	10	1'0	
	Paratabgarh . . .	61,270	61	9'9	
	TOTAL FOR MEYWAR . . .	2,055,542	153	7	
Jodhpore Residency	Jodhpore . . .	2,519,868	534	2'1	
	Sirohee . . .	186,025	47	2'5	
	Jeysulmere . . .	115,701	13	1'1	
	TOTAL FOR JODHPORE . . .	2,821,594	594	2'1	
Bikaner Agency.	Bikaner . . .	831,955	259	3'1	
	TOTAL FOR BIKANER . . .	831,955	259	3'1	
Jeypore Residency	Jeypore . . .	2,832,276	148	5	
	Kishengurh . . .	125,516	12	9	
	Lawa . . .	3,360	3	8'9	
	TOTAL FOR JEYPORE . . .	2,961,152	163	5	
East State Agency.	Bhurlpore . . .	640,303	89	1'3	
	Kerowlee . . .	156,587	20	1'2	
	Dholpur . . .	279,729	73	2'6	
	TOTAL FOR EAST STATE . . .	1,076,619	182	1'6	

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Division.	District.	Total Population on which the Leper-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Ulwur Agency.	Rajputana—contd.				
	Ulwur	767,786	79	1'0	
	TOTAL FOR ULWUR .	767,786	79	1'0	
Jhallawar Agency.	Jhallawar	343,601	92	2'6	
	TOTAL FOR JHALLAWAR .	343,601	92	2'6	
Harowtee and Tonk Agency.	Tonk	380,069	53	1'3	
	Boondee	295,675	69	2'3	
	Shahpura	63,646	1	1	
	TOTAL FOR HAROWTEE AND TONK .	739,390	123	1'6	
Kotah Agency.	Kotah	526,267	63	1'1	
	TOTAL FOR KOTAH .	526,267	63	1'1	
Cantonments.	Erinpura	1,859	Leper population of these cantonments is stated to have been included with their respective states.		
	Kherwara	648			
	Kotna	150			
	Abu	92			
	TOTAL FOR CANTONMENTS .	2,749	—	—	
	Total for Rajputana	12,126,655	1,708	1'4	

Division.	District.	Total Population on which the Leper-ratios have been calculated.	Total number of Lepers.	Proportion per 10,000 of population.	REMARKS.
Central India Agency.	Central India Agency.*				* Incomplete.
	Bhopawar	978,638	1	01	
	Indore	372,792	1	02	
	Gwalior	1,757,509	1	005	
	Western Malwa . .	1,619,368	36	2	
	Bhopal	2,006,859	16	07	
	Bundelkhand . . .	1,508,053	3	01	
	Boona	337,973	22	6	
	Baghaikhand . . .	870,184	—	—	
	TOTAL FOR CENTRAL INDIA AGENCY .	9,451,376	80	08	
	Railways and Cantonments.†				† So far as they have not been included in previous figures—incomplete.
	Aden Settlement .	44,079	1	2	
	Andaman Isles . .	15,609	1	6	
	Bangalore (Civil and Military) .	100,081	12	11	
	Central India Railways .	4,448	—	—	
	Central India Cantonments .	95,235	12	12	
	Total for Railways and Cantonments .	259,455	26	1'0	

CHAPTER IV.

Hereditary Transmission and Predisposition.

THERE is as little consensus of opinion as to the hereditary transmission of leprosy from parent to offspring as there is with regard to the contagiousness of the disease. It is not necessary to enumerate the views of the various authors, and only a few references need be made. Dr. Liveing¹ inclines to the belief in an hereditary predisposition rather than an actual transmission of the disease, while Danielssen and Boeck maintain that hereditary predisposition and transmission are the chief causes of the perpetuation of the disease in Norway.² It should be remarked that the latter authors speak really of an actual hereditary transmission, and not of a mere predisposition. Leloir³ and Hansen,⁴ on the other hand, altogether deny the existence of such transmission or predisposition. Hansen, as is well known, visited North America to enquire into the condition of the Norwegian lepers who had emigrated to that country. Out of 160 original emigrants he found only seventeen alive, and not one of the descendants of these 160 men had contracted leprosy. This fact is most important. Turning now to Virchow⁵ it is found that he says: "The existence of an hereditary tendency has been admitted in all ages and in all countries." But he asserts distinctly that only the predisposition, and not the disease itself, is transmitted: "without special and specific external relations and causes, the disease will not appear in the offspring of leprosy."

(¹) R. Liveing: *Goulstonian Lectures for 1873* (Longmans, Green & Co., London, 1873), pages 84-87.

(²) Danielssen and Boeck: *Traité de la Spedalskhed*. (Paris, 1848); also R. Liveing loc. cit., page 84.

(³) H. Leloir: *Traité Pratique de la Lèpre* (Paris, 1886), pages 281-298.

(⁴) A. Hansen: *Virchow's Archives*, Vol. CXIV., 3, 1888.

(⁵) R. Virchow: *Krankhafte Geschwülste*, Vol. II., pages 503-505.

parents." He continues: "If it be true that amongst the persons who emigrated from Norway to America the disease has disappeared, then we must ascribe a very great importance indeed to these external causes." The proof of this has now been given by Hansen. As regards leprosy in India, Dr. Vandyke Carter,⁶ in his well-known work, strongly urges the spread of the disease through hereditary transmission; and Drs. Lewis and Cunningham,⁷ in their report on Leprosy in India, held "that the hereditary taint exercises a most important influence in the transmission of the pest." However, they never speak of an actual transmission of the disease, but merely of a predisposition.

There can be no doubt that this difference of opinion is in great part due to the fact that authors have not drawn a clear enough distinction between "hereditary transmission of a disease" and "inherited predisposition to a disease." Even now writers talk loosely of the inheritance of carcinoma and tuberculosis, while a predisposition is evidently all that can be claimed. A second mistake, which apparently has been often committed, is that, in their enquiries regarding the condition of the parents, authors have been satisfied with merely ascertaining that the parent or parents were in a diseased condition. But such information is clearly insufficient. In each case, where family taint is possible as a legitimate ætiological factor, it is necessary to enquire also into the time at which the parent or parents were affected. If a child be born of parents who acquire a disease some time after the birth of such child, and the offspring eventually becomes affected also, we cannot ascribe this to inheritance of a specific diseased condition. Such condition can be transmitted to the offspring, only if it were possessed by the parent before the birth of the child. Leloir lays particular stress on this point.

(⁶) Vandyke Carter: *On Leprosy and Elephantiasis*, page 180.

(⁷) T. R. Lewis and D. D. Cunningham: *Leprosy in India*, Calcutta, 1877.

Unfortunately, at the commencement of their investigations, the Commissioners omitted to enquire closely into these circumstances. Thus it frequently happened at that time that no question was asked as to whether or not the parent or parents were healthy at the time of the child's birth. This, as will be seen presently, must materially affect the statistical results, and allowance should be made for this oversight. However, in every case where no statement has been made regarding the condition of the parent at the time of the birth of the offspring, this has been taken as a case of genuine transmission. Nevertheless, even with this admission, the statistical results do not affect the conclusions arrived at by the Commission, as will be fully explained later on.

After due consideration of all the evidence obtained by means of an examination of over 2,000 cases, the Commissioners have come to the conclusion *that leprosy in India cannot be considered an hereditary disease, and they would even venture to say that the evidence which exists is hardly sufficient to establish an inherited specific predisposition to the disease by the offspring of leprosy parents to any appreciable degree.* These deductions have been drawn from the following facts, which, as far as the nature of the matter permits, will be given in tabular form.

Before proceeding further a few general remarks should be made on the subject of hereditary predisposition and transmission, and these will be illustrated by examples derived from the knowledge of tuberculosis. Leprosy and tuberculosis resemble one another in many respects, and the ætiology of the latter disease has been more calmly and carefully considered.

Tuberculosis is essentially a disease of extra-uterine life, and though hereditary in certain instances it is not so as a disease, but as a predisposition. This assertion is not modified in consequence of the two cases published by Landouzy and Martin, Birch-Hirschfeld and Schmorl respectively.^a For in

(^a) Supplement to the British Medical Journal, June 6th and 27th, 1891.

neither case were any tubercles found in the foetal organs, though the presence of tubercle bacilli was proved by microscopical observation and animal experiment. The foetus was still born in either case, and there is thus much room left for speculation as to the ultimate fate of the child, if it had lived. A distinction must clearly be drawn between a congenital or hereditary disease and an infection from the parent through the placental circulation of the child. Instances of congenital tuberculosis have been recorded from time to time, but still are so extremely rare and often also so uncertain as not to invalidate the above statement.

When the influence of heredity in a disease such as leprosy is under discussion, and it is known or proved that the disease itself is not the thing transmitted from parent to child, but only the predisposition to it, great care and caution must be exercised in finding out how far in each case the congenital predisposition has not only been inherited, but also inherited in a legitimate manner. That is, this question must be considered, how far the leprosy of the child is due to the leprosy of its ancestor and how far due to other morbid conditions of the parent, which may have transmitted a congenital predisposition to the child. It must not be forgotten that in leprosy as in tuberculosis a predisposition is necessary for the disease to appear at any time. This predisposition may be due to many agents and factors, and it may therefore be quite possible that the factors which produced the predisposition in the parent, quite apart from the resulting leprosy, may be the cause of the congenital predisposition transmitted to the child. This, however, would not be a legitimate inheritance. Now, where practical questions regarding heredity are under consideration, which may result in such measures as separation of husband and wife or interdiction of marriages between the affected, it is of the utmost importance to study the influence of the disease itself in causing a specific predisposition in the offspring.

The fact, acknowledged equally for tuberculosis and

leprosy, that the diseases occasionally "skip a generation," speaks strongly in favour of a more general than specific form of inheritance, and hence also for the possibility that a non-tubercular or non-leprous condition of the parent may cause the predisposition in the child necessary for the development of tuberculosis or leprosy, as the case may be.

"With tuberculosis it is certain that in the congenital and developmental conditions of the offspring there is nothing of a dyscrasia. When in a tubercular family one child after another dies of tubercular arachnitis, this proves the existence of a specific dyscrasia as little as when in another family one member after another becomes insane. From this it can evidently only be argued that the brain and its membranes hereditarily suffer from certain abnormalities. Even the fact that in the same family one child will be affected with tubercular arachnitis, another with tubercular arthritis, and a third with laryngeal phthisis, does in no way prove the existence of a dyscrasia which in one case attacks the arachnoid, in another the bones, and in a third the larynx. These facts can only prove that the exciting causes select one or other part, and that several areas of the body are in the same predisposed condition."

Mutatis mutandis the same applies to leprosy. And when it is remembered that a predisposition may just as easily be acquired, it is felt that great stress must be laid on the external surrounding conditions. It is therefore necessary to study the effect of a specific hereditary predisposition pure and simple, and carefully exclude the influence of such external relations. It is evidently not sufficient to argue from the fact that a near relation had leprosy, that therefore the congenital predisposition was specifically or legitimately inherited. The congenital predisposition can only be said to have been thus inherited, if the child was actually born of a leprous parent. If born of a parent

(*) For these and the preceding remarks also cf. Virchow, loc. cit., pages 718-720.

who some years, and frequently many years, after the birth of the child becomes a leper, this child cannot possibly be supposed to have inherited a specific leprous predisposition in a legitimate manner. The fact that the parent eventually falls a victim to the disease cannot make the inherited predisposition any more specific or legitimate. This can only prove that certain conditions and abnormalities of the parent, which eventually led to the establishment of a predisposition capable of being acted upon by the exciting causes responsible for the development of leprosy, have been transmitted to the offspring. And even this can only be so, if the possibility of an acquired predisposition in either case can be excluded.

In an investigation of this nature, therefore, it is necessary first to enquire into the number of cases and families in which a specific hereditary predisposition may be assumed actually to exist, that is, to enquire into the condition of the children born of leprous parents. Then it must be seen whether such specific inherited predisposition has a greater influence on the development of the disease than a non-specific congenital predisposition. On this must turn the issue of reformatory measures such as forcible separation of husband and wife and interdiction of marriages. If facts do not establish a greater influence for the former, then the solution of the question cannot be sought in such rigorous rules, but must direct itself to the amelioration of the general external conditions.

These considerations have guided all the subsequent arguments in a complex and difficult question.

I.—A case was never seen of a child leprous at the time of birth, or so shortly afterwards, that it might fairly be considered a congenital case. This point has so often been insisted on by other authors and is so well known a fact that it is unnecessary to comment any further on it. Now it is obviously fatal to the conception of an hereditary transmission of a condition acquired by the parent, if it be established that such condition never appears congenitally. And this fact must be kept in view

more particularly in the investigation of a disease of bacillary origin, for it is easy to conceive that the ovum or embryo could be invaded by the bacillus.

Though this argument tells forcibly against the hereditary transmission of the actual morbid condition or an infection through the placental circulation, a belief in a transmitted specific predisposition might still be maintained. It might be assumed that some constitutional defect causally related to the leprosy of the parent is set up in the embryo, which subsequently, under favourable conditions, gives rise to the disease. Other facts, however, while still further disproving hereditary transmission, cast doubt also upon the possibility of an inherited specific predisposition.

II.—Since leprosy cannot in any case be regarded as a congenital disease, an enquiry must be made as to how often it is possible to trace a family taint in the direct line, from parent to offspring, and to this question the discussion in this chapter will be wholly confined.

From collateral relationship little, if anything, can be argued, as here so inextricable a maze of transmissions exists that it is impossible to disentangle one factor from another. If the facts available with regard to family taint in the direct line be not sufficient to establish inheritance, then *à fortiori*, arguments from collateral relationships must be altogether without force. Dr. Vandyke Carter,¹⁰ who collected information from all parts of the Bombay Presidency, gives a most careful and exhaustive table showing the number and proportion of blood relations, and found that about 20 per cent. of lepers acknowledged a family taint. In 14·5 per cent. of these, however, the taint was in the collateral line. As cousins are included in these 14·5 per cent., it may be submitted that with so much admixture of alien blood little can be deduced from the figures. Arguments and deductions from distant relationships, as *e.g.*

(¹⁰) Vandyke Carter: loc. cit. page 184.

from grandparent to grand-child are of still less force, and of no real scientific value for the subject under discussion. In fact they argue rather against a specific inherited predisposition. It may be well here to repeat the words of Hjort, quoted by Dr. Liveing:¹¹ "From time to time the relationship of many hundred lepers to each other has been carefully investigated, and the result has shown that many of them are more or less akin, and hence the conclusion has been drawn that the disease was hereditary in all those lepers who were related." It will be plain to all that this conclusion does not rest on a sound basis, and that a malady can only be inherited when the seeds thereof pass in a direct line from parents to children, while those persons who are only collaterally related cannot inherit the disease one from another. Lastly, when the term "atavism" is used in support of the theory of heredity, and marked "as a form of inheritance worthy of special notice on account of its frequent occurrence," a protest must be raised against the unwarrantable introduction into human pathology of a term which, whatever its place may be in the province of biological speculations, must remain meaningless to the pathologist enquiring into the ætiology of so markedly a general disease as leprosy. In the study of the inheritance of embryological deformities atavism may be of great importance, but if the term is employed to denote the sudden appearance of a constitutional disease after having "skipped one or several generations," it is inapplicable. Atavism can have no place in the ætiology of leprosy.

Collateral and distant relationships may consequently be disregarded, and the present enquiry is confined to the number of instances in which a family taint could be ascertained to exist in direct lines of descent. This will best be given in a tabular form. The first column of the following table specifies the name of the asylum or locality where the lepers were ex-

(¹¹) R. Liveing: loc. cit., page 85.

amined. The figures are arranged in two columns, (a) number of instances of family taint, regardless of the fact whether the parent or parents were leprosy at the time the child was born, (b) number of instances of leprosy actually born of leprosy parent or parents, after the exclusion of all those cases, where the parent or parents became leprosy sometime after the birth of the child.

TABLE I.

Family Taint in the Direct Line.

NAME OF ASYLUM OR LOCALITY.	No. of cases seen.	No. of cases in which a family taint was confessed.	No. of cases in which parent or parents were leprosy at time of birth of offspring.	REMARKS.
Agra . . .	54	3	1	This case is very doubtful.
Aligarh . . .	10	1	1	No statement made as to condition of parent at time of birth.
Almora . . .	108	17	4	In 1 no statement.
Bangalore . . .	55	4	2	
Belgaum . . .	23	1	1	
Benares . . .	32	1	1	
Bombay . . .	259	34	8	
Burdwan . . .	21	...	...	
Calcutta . . .	89	5	3	In 2 no statement.
Calicut . . .	26	...	...	
Cawnpore . . .	10	..	...	
Conjeevaram . . .	18	5	3	In 1 no statement.
Darjeeling . . .	3	...	...	
Dehra Dun . . .	88	15	6	
Delhi . . .	11	...	...	
Dharmasala . . .	12	3	3	
Fyzabad . . .	17	1	1	
Gwalior . . .	13	1	1	No statement.
Gya . . .	42	6	6	In 6 no statement. 1 very doubtful.
Hyderabad . . .	21	...	...	
Jubbulpore . . .	15	3	2	In both no statement.
Jummoo . . .	2	1	1	No statement.

Table I—continued.

Family Taint in the Direct Line.

NAME OF ASYLUM OR LOCALITY.	No. of cases seen.	No. of cases in which a family taint was confessed.	No. of cases in which parent or parents were leprosy at time of birth of offspring.	REMARKS.
Kapurthalla . . .	10	3	3	In all no statement.
Lahore . . .	2	...	...	
Lucknow . . .	13	...	...	
Madras . . .	184	28	22	In 18 no statement and 3 cases doubtful.
Madura . . .	113	16	7	In 4 no statement.
Mandalay . . .	177	5	3	In all no statement.
Meerut . . .	9	...	...	
Moulmein . . .	25	2	1	
Nagpur . . .	174	7	6	In all no statement.
Naini and Allahabad . . .	66	11	1	In 1 no statement.
Naini Tal . . .	2	...	...	
Patiala . . .	9	1	1	No statement.
Peshawar . . .	2	...	...	
Poona . . .	45	5	4	In one case father, grandfather, and brother leprosy.
Prome . . .	30	1	...	
Purulia . . .	99	18	9	In 5 no statement.
Rangoon . . .	62	5	3	In 3 no statement.
Rawalpindi . . .	47	11	5	In 3 no statement.
Sialkot . . .	40	4	2	
Subathu . . .	46	8	1	In 1 no statement.
Tanjore . . .	16	4	3	In 3 no statement.
Tarn Taran . . .	146	28	9	In 1 no statement.
Thayetmyo . . .	62	8	4	In 2 no statement.
Trichinopoly . . .	16	3	1	No statement.
Umballa . . .	32	5	1	
Yerrowda Prison . . .	15	...	...	
TOTAL . . .	2,371	264	130	No statement in 74 cases.
		= 11.1 per cent.	= 5.48 per cent.	

It will thus be seen that what might be regarded as an hereditary taint in the direct line could be traced in only 130 cases out of 2,371, or in 5.48 per cent. Now, in 74 cases out of the 130 either no statement was made as to the condition of the parent or parents at the time of the child's birth or some doubt was expressed as to diagnosis, and allowing for this, it would perhaps be nearer the mark to say that a true family taint in the direct line could be established in about 4 per cent. of the cases seen.

Family taint in the direct line is, therefore, established in only a few cases, and, consequently, as far as these figures go, one is forced to look for other and more potent causes for the origin of the disease. If the results of Høegh and Bidekap,¹² who traced the disease in the direct line in 25 per cent., and further those of Van Sommeren,¹³ who amongst 31 cases found only two hereditary ones, prompted Virchow to the remark that heredity cannot explain the spread of the disease, how much less do the above figures justify the belief in the high importance of an hereditary influence?

Table I has been constructed from the cases actually seen and examined by the Commissioners. As, however, many patients confessed to having leprosy children or parents, either deceased or absent, it is necessary to construct another table including all these cases. This is done in Table II which is arranged on the same plan as the previous one.

⁽¹²⁾ Høegh and Bidekap: Norsk Magazin for Lægevidenskaben, 1860, Vol. XIV.

⁽¹³⁾ Van Sommeren: A brief Historical Sketch of the Madras Leper Hospital.

TABLE II.
Family Taint in the Direct Line.

NAME OF ASYLUM OR LOCALITY.	No. of cases seen.	No. of cases in which a family taint was confessed.	No. of cases in which parent or parents were lepers at time of birth of offspring.	REMARKS.
Agra	55	4	1	This case is very doubtful.
Aligarh	10	1	1	In 1 no statement.
Almora	113	21	5	
Bangalore	66	5	2	In 1 no statement.
Belgaum	23	1	1	
Benares	32	1	1	
Bombay	260	35	8	
Burdwan	21	...	...	
Calcutta	89	5	3	In 2 no statement.
Calicut	26	...	...	
Cawnpore	10	...	...	
Conjeevaram	19	6	4	In 1 no statement.
Darjeeling	3	...	...	
Dehra Dun	89	16	6	
Delhi	11	...	...	
Dharmasala	12	3	3	
Fyzabad	17	1	1	
Gwalior	13	1	1	In 1 no statement.
Gya	43	7	7	In 1 doubtful diagnosis; 6 no statement.
Hyderabad	21	...	...	
Jubbulpore	16	4	3	In 1 no statement.
Jummoo	2	1	1	In 1 no statement.
Kapurthalla	10	3	3	In 3 no statement.
Lahore	2	...	...	
Lucknow	13	...	...	
Madras	194	35	24	In 3 doubtful diagnosis; 18 no statement.
Madura	115	23	10	In 5 no statement.

Table II—continued.

Family Taint in the Direct Line.

NAME OF ASYLUM OR LOCALITY.	No. of cases seen.	No. of cases in which a family taint was confessed.	No. of cases in which parent or parents were lepers at time of birth of offspring.	REMARKS.
Mandalay . . .	179	5	3	In 3 no statement.
Meerut . . .	9	...	...	
Moulmein . . .	25	2	1	
Nagpur . . .	176	9	7	In 7 no statement.
Naini and Allahabad . . .	66	1	1	In 1 no statement.
Naini Tal . . .	2	...	...	
Patiala . . .	9	1	1	In 1 no statement.
Peshawar . . .	2	...	...	
Poona . . .	45	5	4	
Prome . . .	31	2	...	
Purulia . . .	105	25	10	In 5 doubtful diagnosis. In 4 no statement. In 3 no statement.
Rangoon . . .	62	5	3	In 3 no statement.
Rawalpindi . . .	51	15	7	In 3 no statement.
Sialkot . . .	40	4	2	
Subathu . . .	48	10	1	In 1 no statement.
Tanjore . . .	16	4	3	In 3 no statement.
Tarn Taran . . .	154	36	12	In 2 no statement.
Thayetmyo . . .	63	9	4	In 2 no statement.
Trichinopoly . . .	17	4	1	In 1 no statement.
Umballa . . .	32	5	1	
Yerrowda Prison . . .	16	1	...	
TOTAL . . .	2,423	316 =13.0 per cent.	146 =6.0 per cent.	In 83 insufficient statement.

Thus according to this enlarged table it is seen that a family taint in the direct line existed in 6 per cent., a higher percentage than the corresponding ratio of the former table. But, on the other hand, the number of cases noted as doubtful or as wanting in the detailed statement is greater, and as the additional 52 lepers could not be seen, the suspicion of a wrong diagnosis also is not excluded. Making allowance for all these factors it may be said that this second table fairly represents a percentage of 4.5 of a possible heredity, so that the conclusions derived from a comparison of these two tables are more or less in harmony, and as far as such figures go, establish only to a slight degree the existence of a family taint, and 4 per cent. might, therefore, fairly be accepted as representing the ratio of a specific family taint in the direct line.

These figures tend to confirm Hansen's disbelief in an inherited specific predisposition. In constitutional diseases such as leprosy the greatest caution must be exercised in accepting any theory of inheritance. As the importance of inheritance as an ætiological factor vanishes, so that of external conditions must rise into prominence. And parent and child being subjected usually to exactly similar surrounding conditions and circumstances, it is well within the bounds of probability that the disease has started *de novo* in both. One might otherwise with equal reason classify rickets amongst the hereditary diseases. Now that the pathology of foetal rickets has been elucidated, it is well known that rickets is a disease of bad nutrition and is never congenital or hereditary; yet it would not be difficult in London to find a family taint in 4 per cent. of rickety patients. Unless the influence of external causes can be excluded, and an inheritance proved in a majority of cases and on sound evidence, the hereditary transmission of, or specific predisposition to a disease cannot be said to be established. A protest must be raised when such cases as quoted by M. de Valencé are considered convincing

proofs of an hereditary transmission.¹⁴ For one of his examples of inherited leprosy rests on the "confession of a patient, that he vaguely remembered having heard that his maternal grandmother had had leprosy."¹⁵ His parents apparently were healthy and he himself was certainly untainted when his three children were born. Two of the latter became leprosy and died before the patient himself was affected. The details in the history of inheritance of the other case are too insufficient. Of four sisters and two brothers of apparently healthy descent, the two latter became diseased. One of them died without issue, while the other had a leprosy son. "The sisters had children affected with leprosy, and it is possible at the present day to trace easily the descendants of these four sisters and enumerate the members of the family who died from the disease."¹⁶ Thus as the case stands, a transmission by inheritance can at best only be established from one of the brothers to his son. Yet this evidence, in a leading article of the *Lancet*,¹⁷ has been described as convincing on the question of hereditary transmission. It is on this account only, that notice had to be taken of M. de Valencé's paper.

The great importance of external conditions in the ætiology of leprosy must be admitted, and the figures therefore tend to reduce the importance of inheritance so greatly, that practically it may be altogether disregarded.

Again, if heredity have an appreciable influence on the spread or origin of the disease, it should be possible to trace leprosy through several generations in a sufficiently large number of cases. - In each instance, therefore, when a family taint in the direct line was acknowledged, careful enquiries were made as to the condition of the grand-parents. Only eighteen

⁽¹⁴⁾ *Lancet*, 1890, Vol. I, page 1077.

⁽¹⁵⁾ *Lancet*, 1890, Vol. I, page 1065.

⁽¹⁶⁾ *Lancet*, 1890, Vol. I, page 1077.

⁽¹⁷⁾ *Lancet*, 1890, Vol. I, page 1065.

cases could be obtained where the disease could be traced from the grandfather or grandmother downwards. Now in five cases the statements were insufficient or the diagnosis of leprosy doubtful (Nos. 3, 4, 5, 8, 9), and in further six cases the children were in each instance born of healthy parents, so that the conditions are such as to exclude an inherited specific predisposition (Nos. 1, 11, 12, 13, 14, 15). These cases will now be given in an analysed form.

TABLE IIa.

Analysis of Cases where a Family Taint in the Direct Line could be traced through more than One Generation.

(a) Bombay: (1) Mother = Leper (HER FAMILY HISTORY WAS QUITE CLEAR).

Two sons = both healthy. Daughter = Leper (BECAME A LEPER BEFORE HER MOTHER).

Daughter = Leper. Son = Leper.

Both these children were born when their mother was healthy, and they became affected about the same time as their grandmother, three to five years after their mother. The whole family was seen and examined.

(b) Dehra Dun: (2) Maternal grandfather = Leper.

Mother = Leper.

Daughter = Leper (This patient was seen and examined).

Two children who died as healthy infants.

In each instance the parent was a leper before the birth of the child.

(c) Gya: (3) Father = Leper (HIS FAMILY HISTORY WAS QUITE CLEAR).

Only son = Leper

Only child = Leper

(These two were seen and examined).

In each instance the parent was a leper before the birth of the child.

(d) Kaburthall: (4) Grandmother = Leper (NO STATEMENT MADE, WHETHER PATERNAL OR MATERNAL).

Father = Leper.

Son = Leper (This patient was seen and examined).

No statements were made whether the parent in each instance was a leper before or after the birth of the offspring, nor as to the number of children each parent had.

Table IIa—continued.

Analysis of Cases where a Family Taint in the Direct Line could be traced through more than One Generation.

(e) *Madras*: (5) Grandfather = Leper (No STATEMENT MADE, WHETHER PATERNAL OR MATERNAL).

Mother = Leper.

Son = Leper (This patient was seen and questioned).

Three children (one of them said to be a leper, but diagnosis extremely doubtful).

(6) Father and Mother = Lepers.

Two daughters = Lepers (These two and the child were seen and examined).

One of these has a child = Leper (BUT DIAGNOSIS IS EXTREMELY DOUBTFUL).

(7) Maternal grandfather = Leper.

Mother = Leper (This patient and her leprous child were seen).

Two children and one of them = Leper (the other is healthy, married and has several healthy grown up children).

(8) Maternal grandfather = Leper.

Mother = Leper.

Daughter = Leper (This patient was seen and examined).

(f) *Madras*: (9) Father = Leper (His FAMILY HISTORY QUITE CLEAR).

Only child = Leper.

Two children and one of them = Leper (BUT DIAGNOSIS WAS EXTREMELY DOUBTFUL).

(g) *Poona*: (10) Grandfather = Leper.

Father and Mother = Lepers.

Two sons = Lepers (These two were seen and questioned).

(h) *Purulia*: (11) Grandparents on one side = Lepers.

Parents = Lepers.

Two out of five children = Lepers (These two were seen: all adults).

(12) Mother = Leper (HER OWN FAMILY HISTORY CLEAR).

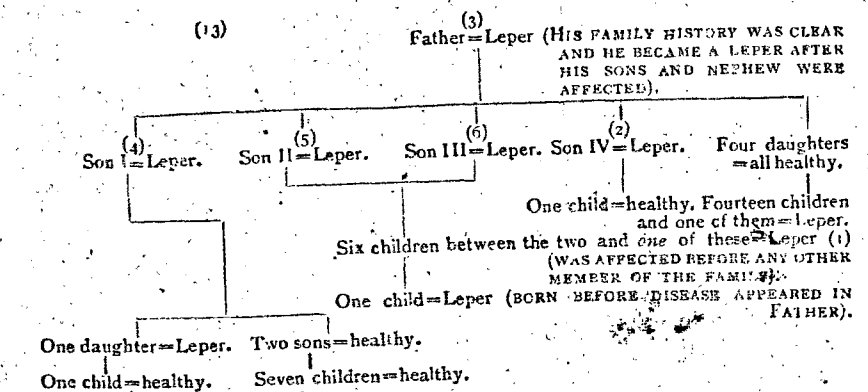
Son = Leper. Daughter = Leper (BOTH SON AND DAUGHTER BORN LONG BEFORE MOTHER BECAME A LEPER).

Two sons = Lepers (BOTH BORN BEFORE MANIFESTATION OF DISEASE IN THEIR MOTHER).

The whole family was seen and questioned.

Table IIa—continued.

Analysis of Cases where a Family Taint in the Direct Line could be traced through more than One Generation.



Remarks.—In each case the offspring was born long before the disease appeared in the parent. Six members of this family were examined individually and separately, and an absolute uniformity of statements obtained. The figures in brackets indicate the order in which the disease appeared in the various members of this family. The father acquired leprosy one year or so before his death and was an old man at the time of his death.

(14) Mother = Leper (HER OWN FAMILY HISTORY WAS CLEAR).

Two sons = healthy. One daughter = Leper (ACQUIRED THE DISEASE LONG BEFORE HER MOTHER).

Two sons = Lepers (BORN AFTER THE MANIFESTATION OF THE DISEASE IN THEIR MOTHER).

The whole family was seen and questioned.

(i) *Torn Tarap*: (15) Father and Mother = Lepers (THEIR OWN FAMILY HISTORY WAS CLEAR AND THEY ACQUIRED THE DISEASE AFTER ALL THEIR CHILDREN WERE BORN).

Three sons = Lepers. One daughter = Leper (SHE MARRIED WHILE HEALTHY AND SEPARATED FROM HUSBAND AS SOON AS THE DISEASE APPEARED IN HER).

One child = Leper (DIED AT THE AGE OF 12 YEARS AND WAS BORN SEVERAL YEARS BEFORE THE MOTHER BECAME AFFECTED).

Four members of this family were seen and questioned.

(16) Father = Leper (His OWN FAMILY HISTORY IS CLEAR).

Son I = Leper. Son II = Leper (BOTH BORN LONG BEFORE APPEARANCE OF LEPROSY IN THE FATHER).

One son = Leper (ALSO BORN LONG BEFORE APPEARANCE OF DISEASE IN HIS FATHER).

The whole family was seen and examined.

Table IIa—concluded.

Analysis of Cases where a Family Taint in the Direct Line could be traced through more than One Generation.

- (17) Father=Leper (HIS OWN FAMILY HISTORY WAS CLEAR).
 Son I=healthy. Son II=Leper (BOTH BORN AFTER THEIR FATHER BECAME A LEPER).
 One daughter=Leper.
 (k) *Thayemyo*: (18) Mother=Leper (HER OWN FAMILY HISTORY WAS CLEAR).
 Seven children and one of them=Leper.
 Two children and one of them=Leper (DIAGNOSIS EXTREMELY DOUBTFUL).

Here no statements were made as to date of appearance of leprosy in the parents.

Even allowing that in a certain number of cases the patients knew little of their grandparents, if heredity exercised any appreciable influence on the spread of leprosy, it should have been possible to obtain a far greater number of cases where the disease could be traced through two generations at least. As, however, all the doubtful cases have been included, the figures may be assumed to represent the truth as nearly as possible. Accepting even all the eighteen cases the ratio would still be less than 1 to 100. Now in a disease like leprosy it may be urged that in most leprosy families the grandchildren would have knowledge of the condition of their immediate ancestors. Again this analysis shows the necessity of a careful enquiry in each case into the time at which the parent or parents became leprosy, for it would evidently be absurd to consider Case 13 an instance of hereditary transmission, as here the grandchild actually acquired the disease before the common ancestor. In Cases 1 and 14 the child also became affected before the mother. In such instances it obviously cannot be a specific predisposition based on the existence of leprosy in the parent which has been transmitted to the offspring. If a predisposition has been transmitted to the child, it must have been the physiological or anatomical conditions which have rendered the ancestor a favourable subject for the

de novo acquisition of the disease, but it is certainly not a legitimate inheritance of a leprosy predisposition. For whatever the child inherited it would have inherited, whether the parent subsequently became a leper or not. And excluding contagion it may be quite possible that in all the members of the family the disease started *de novo*, the necessary predisposition having been acquired. To allow such cases as proofs of an inherited specific predisposition would obviously be a "post hoc ergo propter hoc" argument.

III.—From the fact that leprosy occurs often in several members of a family, authors have argued the existence of a specific hereditary predisposition. That such an argument cannot hold good may be seen from the fact that instances occur where two or three brothers or sisters simultaneously suffer, although they are not aware that they had any leprosy ancestors. Leloir lays special stress on this point; and doubtless if it can be shown with sufficient frequency that several children become affected, while the parents remain healthy, this fact, coupled with the small percentage of direct family taint, found in the present enquiry, would still further diminish the importance of heredity as a cause of the continuance of the disease. It would tend to show that individuals habitually exposed to the same conditions are liable to be affected in the same manner. And as often years elapse between the appearance of the disease in two children of the same family, it reduces the importance of heredity still further. The fact of the parent being a leper before the birth of the child does not alter this statement, for it has been found in many cases that the son of a leprosy parent contracted the disease long before his younger brother, destined subsequently to become a leper, was born.

Enquiring into this matter, it is found that in 101 instances, or in about 4.5 per cent. of the cases examined, two or more children became lepers, while their parents were perfectly healthy, and in most of these cases no other relative was affected. The correspondence of this ratio with the above is remarkable.

In this case heredity can of course have played no part, as it is impossible to look to atavism for support, for the reasons assigned above. The conclusion is strongly suggested that though the disease in a small proportion of cases appears to run in families, this cannot be ascribed to a specific inherited predisposition.

A table is given showing the distribution of these cases amongst the various asylums and places visited.

TABLE III.

Instances where two or more Children were Lepers but their Parents healthy.

NAME OF ASYLUM OR LOCALITY.	No. of instances.
Agra	1
Aligarh	1
Almora	13
Bombay	7
Calcutta	2
Conjeeveram	3
Darjeeling	1
Dharmasala	1
Dehra Dun	6
Gya	2
Hyderabad	1
Jubbulpore	1
Madras	12
Madura	9
Mandalay	6
Prome	2
Purulia	7
Rangoon	1
Rawalpindi	5

Table III—continued.

Instances where two or more Children were Lepers but their Parents healthy.

NAME OF ASYLUM OR LOCALITY.	No. of instances.
Sialkot	3
Subathu	3
Tarn Taran	8
Thayetmyo	3
Umballa	3
TOTAL	101

IV.—Perhaps the best method of studying the influence of heredity is to enquire into the condition of the children born of leprous parents, the latter having been lepers since their marriage. As will be seen from the subjoined table, 98 leprous couples had 65 children, and of these three became lepers. Two cases were so exceedingly doubtful that they may justly be excluded. Thus it is found that 4.6 per cent., or accepting the doubtful cases, 7.6 per cent. of the issue of leper marriages have contracted the disease. Some, though very few, of the children were still young, and one or two of them may subsequently develop leprosy. These figures therefore lead to results almost identical with those of Tables I and II. Yet here the most favourable conditions for the full play of inheritance existed, and nevertheless, the actual percentage of hereditary cases is less. If a specific hereditary transmission exercised any considerable influence, a much greater number of the 65 children should have become affected. And in order that no misapprehension may exist regarding the value of the figures given in Table IV, particular attention is drawn to the fact that the majority of these cases of the issue of leprous parents

are adults, perfectly healthy, some married and with healthy children. A certain number, on the other hand, died healthy. These figures, therefore, give little support to the view of a legitimately inherited predisposition to the disease.

TABLE IV.

Cases where Father and Mother were Lepers at the Time of Marriage.

NAME OF ASYLUM OR LOCALITY.	No. of couples.	No. of persons these couples represent.	No. of children.	No. of children who became lepers.
Almora .	22	43	21	1
Belgaum .	1	2	...	...
Bombay .	3	6	...	...
Dehra Dun .	4	7	2	...
Kapurthalla .	2	4	3	1 (?)
Lucknow .	2	4	...	...
Madras .	1	2	2	...
Mandalay .	1	2	...	...
Meerut .	6	12	...	...
Nagpur .	1	2	...	...
Patiala .	1	2	1	...
Rangoon .	1	2	...	...
Rawalpindi .	14	26	10	1 (?)
Sialkot .	14	26	3	2
Subathu .	2	4	5	...
Tarn Taran .	22	42	18	...
Umballa .	1	2	...	...
TOTAL	98	188	65	3 or 5=4.6 per cent. or 7.6 per cent.

V.—The only decisive way of disentangling the influence of heredity and external conditions would be to imitate the

experiment of the emigrant Norwegian lepers, and to remove the offspring of lepers not only from their parents but also into an area where leprosy is not endemic. Placed under such conditions, with good food and hygienic surroundings, heredity would have full and absolute play. There are two asylums in India where children born of leprosy parents are kept apart from them and tended with great care; this is done at Almora and Purulia. The latter unfortunately has not been sufficiently long in existence, hardly more than two years. The Almora Orphanage, however, is much older and thus capable of affording very valuable information. The children born of either one or two leper parents are removed from their surroundings and carefully attended to in the Orphanage. Endemic influences cannot of course be excluded. Drs. Lewis and Cunningham¹⁹ say in their report: "There are at present (1877) in the Orphanage of Almora 12 children of lepers now or formerly in the Asylum. The total number of such children who have been admitted into the Orphanage is 14, but of these 1 died, and another, a girl of 22, has now left the Orphanage, is married, and has children healthy to all appearance. Of the 12 remaining 7 were born in the Asylum of two leprosy parents; 5, the offspring of one leprosy and one healthy parent, were born in the villages to which their parents belonged. Their ages ranged from 19 to 5 years; their health and general condition is excellent, and as yet they show no signs of leprosy."

The Commissioners were able to ascertain the corresponding facts with regard to 23 inmates of the Orphanage. Of these three were born before the manifestation of the disease in the parent, their ages being 31, 28, and 19, respectively, and five were under 10 years, their ages ranging from 7 years to 6 months (7, 7, 4, 3, and $\frac{1}{2}$ years, respectively). All these eight individuals were up to date in good health. This leaves 15 cases, and of these, as will be seen from Table V, only 1 has

⁽¹⁹⁾ Loc. cit., page 67.

contracted the disease, all the others having remained perfectly well, or having died free from leprosy in adult age. The number of children is certainly not a large one, and deductions should naturally be made with care, but the figures, especially if compared with the other ratios obtained, tend still further to diminish the importance of heredity. For omitting the eight cases, for the reasons mentioned, an assumed hereditary transmission was traceable in 6.6 per cent.

TABLE V.

Almora Asylum Orphanage.

No.	Sex.	Age.	Condition of parents at birth.	Period spent with parents.	Period spent in Asylum previous to admission into Orphanage.	Period spent in Orphanage.	Present condition.
1	Female	28 years	Father and mother lepers.	2 years	2 years	16 years	Healthy at 28 years of age.
2	"	28 "	Ditto	2 "	3 "	15 "	Healthy up to date.
3	"	27 "	Ditto	1 year	2 "	24 "	Ditto.
4	"	25 "	Father healthy; mother leprous.	8 years	6 "	11 "	Healthy; died of diarrhoea.
5	"	24 "	Father and mother lepers.	2 months	3 "	20 "	Healthy up to date.
6	"	22 "	Father healthy; mother leprous.	1 year.	1 year	20 "	Ditto.
7	"	21 "	Ditto	7 months	2 years	25 "	Healthy; died of phthisis.
8	Male	21 "	Father and mother lepers.	2 years	4 "	11 "	Leprosy for last 4 years.
9	Female	20 "	Ditto	2 "	2 "	15 "	Healthy; died of epilepsy.
10	"	18 "	Ditto	1 year.	1 year.	16 "	Healthy up to date.
11	"	17 "	Father healthy; mother leprous.	5 years	31 years	81 "	Ditto.
12	Male	15 "	Father and mother lepers.	6 "	...	9 "	Ditto.
13	Female	14 "	Ditto	1 year.	2 years	11 "	Ditto.
14	"	13 "	Father leprous; mother healthy.	10 years	2 "	1 year	Ditto.
15	Male	12 "	Father and mother lepers.	2 "	...	10 years	Ditto.

VI.—In the fourth section the condition of children born of two leprous parents was enquired into. Here the condition of all the children born after the manifestation of the disease in one or other parent will be considered. It must be remarked that in many cases the children could not be personally examined by the Commissioners, and in these cases the parent's statements had to be accepted. Doubtless this is a source of error and due allowance must be made. It was found that amongst 500 children of all ages born of either two leprous parents, or from one leper parent and one healthy parent, 21, or 4.2 per cent., became lepers. In eight of these the existence of the disease was extremely doubtful, while in some others no statements were made as to the condition of the parent or parents at the time of the child's birth. Even if 19 be accepted as the actual number of the offspring attacked, the ratio yielded very nearly approaches the truth. But as some children were still young it may be objected that they had not yet reached the age at which leprosy generally shows itself, and it is desirable to re-arrange the offspring in two classes—(a) all those of ten years and over, and (b) all those of sixteen years and over. Taking ten as the minimum age, it was found that there were 150 individuals born after the appearance of the disease in the parent or parents, and of these 10 had become lepers, or 6.6 per cent. Again, taking sixteen as the minimum age, there were 82 individuals born of leprous parents, of whom six subsequently contracted the disease, or 7.31 per cent. Making all allowances for errors in diagnosis and inaccurate statements, it will be apparent that the figures correspond closely with those of former tables.

TABLE VI.

Condition of Children born after Manifestation of Disease in Parent or Parents.

NAME OF ASYLUM OR LOCALITY.	No. of children.	No. of children affected.	REMARKS.
Agra	15	...	
Aligarh	5	...	All young.
Almora	29	1	
Bangalore	20	1	Very doubtful diagnosis.
Belgaum	2	...	10½ years old.
Benares	5	...	8½ years old.
Bombay	10	2	
Burdwan	5	...	
Calcutta	12	...	
Calicut	20	...	
Cawnpore	5	...	All under 10 years.
Conjeeveram	12	2	10½ years old.
Darjeeling	2	...	Under 6 years.
Dehra Dun	20	1	Very doubtful diagnosis.
Delhi	6	...	All under 6 years.
Dharmasala	1	...	
Fyzabad	4	...	
Gwalior	3	...	Under 12 years.
Gya	5	1	9½ years old.
Hyderabad	16	...	From 11½ years old.
Jubbulpore	9	...	
Jummoo	1	...	6 years old.
Kapurthalla	3	1	Aged 25; very doubtful diagnosis.
Lucknow	1	...	

Table VI—continued.

Condition of Children born after Manifestation of Disease in Parent or Parents.

NAME OF ASYLUM OR LOCALITY.	No. of children.	No. of children affected.	REMARKS.
Madras	43	3	2 very doubtful.
Madura	56	2	
Mandalay	35	...	All adults.
Meerut	3	...	
Moulmein	9	1	Very doubtful.
Nagpur	30	...	
Naini and Allahabad	17	...	
Naini Tal	1	...	
Patiala	1	...	
Prome	3	...	
Purulia	4	1	Very doubtful.
Rangoon	9	...	
Rawalpindi	12	2	No statement made.
Sialkot	4	2	All adults; no statement made.
Subathu	11	...	
Tanjore	1	...	Under 5 years old.
Tarn Taran	34	...	
Thayetmyo	5	1	Very doubtful.
Trichinopoly	7	...	All under 10 years old.
Umballa	1	...	18 years old.
Yerrowda Prison	3	...	Under 7 years old.
TOTAL	500	21 = 4.2 per cent.	

TABLE VII.

Condition of Children born after the Manifestation of the Disease in the Parent or Parents, taking 10 years as the Minimum Age.

NAME OF ASYLUM.	No. of children.	No. of children affected.	REMARKS.
Agra	3	...	
Aligarh	1	...	
Almora	23	1	
Bangalore	4	...	
Belgaum	1	...	
Benares	3	...	
Bombay	2	1	
Calcutta	1	...	
Calicut	10	...	
Conjeeveram	1	1	
Dehra Dun	6	...	
Hyderabad	2	...	
Jubbulpore	2	...	Very doubtful diagnosis.
Kapurthalla	3	1	12 years old.
Lucknow	1	...	
Madras	4	...	
Madura	17	1	
Mandalay	10	...	
Meerut	3	...	
Nagpur	12	...	
Naini and Allahabad	7	...	
Patiala	1	...	
Prome	1	...	
Purulia	3	1	Very doubtful diagnosis.
Rangoon	1	...	
Rawalpindi	4	2	
Sialkot	4	2	

Table VII—continued.

Condition of Children born after the Manifestation of the Disease in the Parent or Parents, taking 10 years as the Minimum Age.

NAME OF ASYLUM.	No. of children.	No. of children affected.	REMARKS.
Subathu	4	...	
Tarn Taran	13	...	
Thayetmyo	2	...	
Umballa	1	...	
TOTAL	150	10 = 6.6 per cent.	

TABLE VIII.

Condition of Children born after the Manifestation of the Disease in the Parent or Parents, taking 16 years as the Minimum Age.

NAME OF ASYLUM.	No. of children.	No. of children affected.	REMARKS.
Agra	2	...	Ages 19 and 16.
Almora	13	1	
Benares	1	...	
Bombay	2	1	
Calicut	2	...	
Dehra Dun	5	...	
Hyderabad	1	...	
Kapurthalla	3	1	Very doubtful diagnosis.
Madras	3	...	
Madura	6	...	
Mandalay	8	...	
Meerut	3	...	

Table VIII—continued.

Condition of Children born after the Manifestation of the disease in the Parent or Parents, taking 16 years as the Minimum Age.

NAME OF ASYLUM.	No. of children.	No. of children affected.	REMARKS.
Nagpur	7	...	Very doubtful diagnosis.
Naini and Allahabad	7	...	
Trame	1	...	
Purulia	3	1	
Rawalpindi	1	...	
Sialkot	4	2	
Subatha	1	...	19 and 16 years old. 18 years old.
Tarn Taran	6	...	
Thayetnyo	2	...	
Umballa	1	...	
TOTAL	82	6 = 7·31 per cent.	

VII.—Lastly, the influence of an inherited specific predisposition may be studied by the selection of cases in which a family taint in the direct line can be traced, and by an enquiry into the condition of the brothers and sisters. Now, as was shown above, in many instances where there is evidence of a family taint, the patients were born at a time when their fathers and mothers were absolutely healthy though they afterwards became lepers. These cases might be termed instances of "false heredity." Again others were actually born of a leper parent or parents. If new tables be constructed with a view to showing how many of the brothers and sisters of lepers with a "false" hereditary history have become lepers in comparison with the number of brothers and sisters of lepers with a "true" hereditary history who have become lepers, addi-

tional light will be thrown upon the influence of heredity. For, in the former case, the predisposition cannot have been legitimately inherited, and, if hereditary, must be related to general non-specific conditions of the parent. In the case of patients actually born of leprosy parents great care has been taken to ascertain that their brothers and sisters were also born after the manifestation of the disease in the parent or parents. In some cases no statements were made, and it is quite possible that some of the brothers and sisters were born at a time when their immediate ancestors were healthy. In other cases, with regard to the patient himself, whose brothers and sisters form the subject of the present enquiry, no statement was made as to whether he or she had a true or false history of heredity. These cases have been entered as though they were instances of true heredity, and thus errors in statistics are more or less counterbalanced, and the statistics placed in a more favourable light from the heredity point of view.

It has been found that 62 patients with a true hereditary history had 156 brothers and sisters born also, as far as could be ascertained, after the manifestation of the disease in their fathers and mothers; and of these 21 became lepers, or 13·4 per cent.

On the other hand, 61 patients, with a history of false heredity, had 150 brothers and sisters, and of these 31, or 20·6 per cent., were lepers. This is certainly a most surprising result, and, if coupled with the number of instances of several children becoming lepers while their parents remained healthy, removes the importance attributed to a specific hereditary predisposition. The figures are certainly somewhat small, but yet allow of decisive conclusions being drawn from them. Now, even if the cases with insufficient statements be excluded from Table IX, and added to Table X, the ratio would still militate against the influence of an actual heredity. For, in spite of making such allowances, the ratio could not be reduced below 15 per cent. or 20 per cent. This appears to be a strong argument against

inheritance, for if this agency had much influence the ratios should not only be reversed, but the percentage of lepers in Table IX ought to be much greater than that of Table X. The only inference to be drawn from these tables, and from the fact of children being often affected though their parents remain healthy, is that leprosy appears to have a tendency to attack several members of a family, but that a legitimate specific hereditary transmission cannot be regarded as the cause. In another place it will be shown whether contagion can explain this fact. It should never be forgotten that a disease due to extraneous agents and conditions, such as leprosy seems to be, may at any time affect people living in similar surroundings and possessing similar constitutions. And it is precisely amongst the members of a family that we get such conditions and relations. However this will be dealt with more fully in the chapter on Contagion.

TABLE IX.

Condition of the Brothers and Sisters of Leprous Patients with a "True" History of Heredity.

NAME OF ASYLUM OR LOCALITY.*	No. of patients actually born of leper parents.	No. of their brothers and sisters.	No. of these affected.	REMARKS.
Agra	1	4	...	Doubtful.
Aligarh	1	2	...	No statement.
Almora	1	1	...	
Bangalore	3	7	...	
Belgaum	1	2	...	
Benares	1	2	...	
Calcutta	2	4	...	
Dehra Dun	4	9	1	

* Bombay has been omitted on account of insufficient details, as in no case the number of brothers and sisters was stated.

Table IX—continued.

Condition of the Brothers and Sisters of Leprous Patients with a "True" History of Heredity.

NAME OF ASYLUM OR LOCALITY.*	No. of patients actually born of leper parents.	No. of their brothers and sisters.	No. of these affected.	REMARKS.
Dharmasala	2	5	1	No statement.
Gwalior	1	5	...	
Gya	5	12	...	No statement.
Jubbulpore	1	1	1	Ditto.
Jummoo	1	3	...	
Madras	10	28	8	In some no statement.
Madura	2	6	1	No statement.
Nagpur	4	7	1	
Naini and Allahabad	1	2	...	No statement.
Patiala	1	1	...	
Poona	1	1	1	
Purulia	3	7	2	
Rangoon	1	1	...	No statement.
Rawalpindi	4	11	1	
Sialkot	1	4	...	
Tanjore	1	4	...	
Tarn Taran	4	10	3	
Trichinopoly	1	6	...	No statement.
Thayetmyo	3	8	1	
Umballa	1	3	...	
TOTAL	62	156	21 = 13.4 per cent.	

* Bombay has been omitted on account of insufficient details, as in no case the number of brothers and sisters was stated.

TABLE X.

Condition of Brothers and Sisters of Leprous Patients with a "False" History of Heredity.

NAME OF ASYLUM, ETC.	No. of patients with such history.	No. of their brothers and sisters.	No. of these affected.	REMARKS.
Agra	2	3	1	Bombay has been omitted for the reason given in footnote, page 236.
Almora	10	29	5	
Bangalore	2	4	...	
Conjeeveram	1	4	1	
Dehra Dun	4	16	...	
Fyzabad	1	2	...	
Jubbulpore	2	8	...	
Madras	5	13	3	
Madura	3	8	3	
Mandalay	2	5	...	
Purulia	9	22	8	
Rangoon	1	1	...	
Rawalpindi	3	4	1	
Sialkot	1	1	...	
Subathu	2	2	2	
Tarn Taran	7	13	6	
Thayetmyo	1	1	...	

Table X—continued.

Condition of the Brothers and Sisters of Leprous Patients with a "False" History of Heredity.

NAME OF ASYLUM, ETC.	No. of patients with such history.	No. of their brothers and sisters.	No. of these affected.	REMARKS.
Trichinopoly	2	8	1	
Umballa	3	6	...	
TOTAL	61	150	31 = 20.6 per cent.	

A glance at Tables IX and X might at first sight lead to the belief that the children born of lepers or of parents who became lepers at any time after the birth of these children suffer more frequently from leprosy than do the children born of people remaining free from the disease. To enquire into the truth of this statement a Table, X₇, has been added to show the condition of the brothers and sisters of leprosy patients born of parents healthy before and after the birth of such patients. It has been found that 850 patients had 2,853 brothers and sisters, of whom 97, or 3.4 per cent., subsequently contracted leprosy. On the other hand, from Tables IX and X, it will be seen that 123 patients with a history of "true" or "false" heredity had 306 brothers and sisters, of whom 52, or 17.0 per cent., subsequently became affected.

Does this prove a specific hereditary influence or predisposition? Now it is evident that from Table IX no conclusion can be drawn as to the fate of the offspring of leprosy patients as a whole, for here only those families have been selected where one parent and one child at least are lepers, and where a specific hereditary influence may actually be assumed to exist, the child in each instance being born of a leprosy parent. All those cases, however, have been omitted where a leprosy parent had absolutely healthy children. Table IX does not

therefore assert anything about *all* the children born of leprous parents. How many of these become diseased has been considered in previous paragraphs. Selecting, however, those families where, through the fact that one child is affected like its parent, a specific hereditary predisposition is granted to exist—and of such only a small number was found—Table IX shows that contrary to expectation of 218 children with such an inherited predisposition only 83, or 38 per cent., became lepers. That this ratio should be higher than in Table Xa simply amounts to stating that in these families the assumed hereditary taint actually exists, but it says nothing as to the number of children born of leprous parents who subsequently become lepers. Table IX, therefore, clearly cannot be contrasted with Table Xa with a view of finding out the greater predisposition of the offspring of leprous parents as a whole.

A similar objection must be raised when Table X is employed to prove the same assumption. For here only those families are chosen where one child at least became a leper, while those children which permanently remained healthy have been excluded. To make the conclusion as to the offspring in general a legitimate one, *all* the children born of such parents who, though healthy at the time of birth of these children, subsequently became lepers, should be considered. A comparison of Tables X and Xa can evidently only prove this, that in those families where a parent becomes a leper after the birth of his children, and where also at least one of these children subsequently becomes a leper, the children as a whole are more liable to suffer from the disease, just as a comparison of Tables IX and Xa can only show that in those families where at least one parent is a leper before the birth of his children, and where also at least one of these children subsequently becomes a leper, the children as a whole are somewhat more liable to suffer from the disease than the children in those families where the parents are healthy, and remain so, while at least one child is a leper.

But clearly all this does not prove anything in favour of a specific hereditary predisposition causally related to the leprosy in the parent. In fact, it argues strongly for an acquired predisposition both by the parents and the children, and this in the case of the latter may have been facilitated by some congenital abnormality not related to leprosy, but inherited from the former.

On the other hand, it seems astonishing from a consideration of Table Xa, that selecting those families where the parents were healthy, but one child at least a leper, of 850+2,853 or 3,703, children 850+97 or 947 individuals, or 25 per cent., should have become lepers, though the parents, as far as could be ascertained, were free from any family taint in the direct line. The same percentages for Tables IX and X would be 37 and 43.6, respectively. It might now be well to compare these figures with results obtained from a consideration of such families where the parents remained healthy, and were confessedly free from any family taint in the direct line, but at least two of the children were lepers. It will be seen from Table Xb that in such families 96 patients had 292 brothers and sisters, of whom 111 were lepers: or that selecting these families, of 388 children 207, or 53.3 per cent., were diseased. This is very instructive, as though here an hereditary specific predisposition is excluded as rigorously as possible, yet the disease shows a predilection for certain families.

It is only when examined in this light, that deductions regarding the offspring as a whole can be made with a view to elicit the influence of a specific hereditary predisposition. Now as individuals of alien blood, such as husbands and wives of lepers who live with the family under similar conditions, suffer to the extent of from 5 to 6 per cent., the above arguments are strengthened.¹⁹ Evidently all that can be argued from these considerations is, that leprosy in a certain number of instances

⁽¹⁹⁾ Cf. Chapter on Contagion.

has a tendency to affect several members of a family, but that this is not due to a specific hereditary predisposition.

TABLE Xa.

Condition of Brothers and Sisters of Leprous Patients whose Parents remained Healthy.

ASYLUM OR LOCALITY.	No. of patients with such history.	No. of their brothers and sisters.	No. of these affected.	REMARKS.
Aligarh	6	12	1	It must be remarked, that in several instances when the brothers and sisters of a leper were healthy, their number had not been enquired into, or at times no mention at all made of them. On the other hand, whenever a leper had a leprosy brother or sister, full information has always been given. Taking due consideration of this fact, it is evident that the percentage at the end of this table is too high. Agra, Bombay, Calicut, Hyderabad, Sukathi and Tarn Taran have been omitted on account of insufficient details. Omissions, however, though few, exist also in some of the other stations. Making due allowance for these, it may be said that 2 per cent. indicates the true ratio.
Almora	74	256	16	
Bangalore	21	71	...	
Belgaum	2	9	...	
Benares	13	32	...	
Calcutta	67	245	2	
Cawnpore	5	11	...	
Conjeeveram	12	54	3	
Darjeeling	1	4	1	
Dehra Dun	67	228	6	
Delhi	7	23	...	
Dharmasala	7	17	2	
Gwalior	9	35	...	
Gya	30	98	3	
Jubbulpore	5	15	1	
Kapurthalla	1	1	...	
Lahore	1	4	...	
Lucknow	2	4	...	
Madras	59	214	15	
Madura	47	209	9	
Mandalay	136	495	7	
Moulmein	16	53	...	
Nagpur	53	131	...	

Table Xa—continued.

Condition of Brothers and Sisters of Leprous Patients whose Parents remained Healthy.

ASYLUM OR LOCALITY.	No. of patients with such history.	No. of their brothers and sisters.	No. of these affected.	REMARKS.
Naini and Allahabad	8	31	1	
Naini Tal	1	2	...	
Patiala	8	27	1	
Prome	24	65	2	
Purulia	18	41	9	
Rangoon	41	122	1	
Rawalpindi	19	54	6	
Sialkot	22	75	4	
Tanjore	9	31	...	
Thayetmyo	46	156	4	
Trichinopoly	5	20	...	
Umballa	8	18	3	
TOTAL	850	2,853	97 = 3.4 per cent.	

TABLE Xb.

Condition of Brothers and Sisters of Leprous Patients belonging to Families where the Parents remained healthy, but at least Two Children were Lepers.

ASYLUM OR LOCALITY.	No. of patients belonging to such families.	No. of their brothers and sisters.	No. of these affected.	REMARKS.
Agra	1	1	1	
Aligarh	1	1	1	
Almora	13	49	16	

Table Xb—continued.

Condition of Brothers and Sisters of Leprous Patients belonging to Families where the Parents remained healthy, but at least Two Children were Lepers.

ASYLUM OR LOCALITY.	No. of patients belonging to such families.	No. of their brothers and sisters.	No. of these affected.	REMARKS.
Calcutta . . .	2	8	2	
Conjeeveram . . .	3	13	3	
Darjeeling . . .	1	4	1	
Dehra Dun . . .	6	28	6	
Dharmasala . . .	1	4	2	
Gya . . .	2	8	3	
Hyderabad . . .	1	1	1	
Jubbulpore . . .	1	1	1	
Madras . . .	12	25	15	
Madura . . .	9	34	9	
Mandalay . . .	6	26	7	
Naini and Allahabad . . .	1	1	1	
Patiala . . .	1	6	1	
Prome . . .	2	8	2	
Purulia . . .	7	17	9	
Rangoon . . .	1	1	1	
Rawalpindi . . .	5	15	6	
Sialkot . . .	3	5	4	
Subathu . . .	3	3	3	
Tarn Taran . . .	8	22	9	
Thayetmyo . . .	3	8	4	
Umballa . . .	3	3	3	
TOTAL . . .	96	292	111 = 37.9 per cent.	

VIII.—Before giving a summary of this chapter, a few remarks must be made upon a point which has an important bearing on the question of heredity: what will be the risk of increase to the leper population, assuming heredity to be a more or less influential agent in the spread of the disease? This matter was thoroughly gone into by Drs. Lewis and Cunningham,²¹ who came to the conclusion that "taking all the information attainable there appears to be no great risk of increase to the leper population of Kumaun as far as the disease is dependent on heredity for its multiplication."

Following their line of argument, it will be seen, by referring to Table XI, that 2,915 children were born before or after the manifestation of leprosy in the parent or parents. Almora and Meerut have been left out of consideration, because the total number of children could not be obtained in all instances where both the parents were lepers.

Strictly speaking, only the children actually born of lepers should be considered. However, as here the greatest possible increase to the leper population is under discussion, and this matter is simply a side issue to the question of heredity and of practical rather than scientific value, all objections will be waived, and all the children included. Thus the case will be stated as strongly as possible. Besides, the fact exists that whether the parent was a leper before or after the birth of his children, a certain number of the latter suffer at one time or another. Whether this is due to a specific hereditary influence has been previously discussed, and for the present purpose it will be best simply to accept the fact, and enquire what would be the probable increase to the leper population.

In Table XI all those children who died in infancy have been excluded for obvious reasons. Now 2,915 children have been the issue of 1,564 marriages. These marriages have been grouped together in Tables XII and XIII. Of these 71 were contracted by individuals both suffering from the disease, so

⁽²¹⁾ Loc. cit., page 63.

that these would represent 142 lepers. This is not quite correct, as some patients married twice. But while facilitating calculations, it will in no way affect the ratio, and moreover will compensate for omissions among the other leper marriages. These were contracted between a leper and a healthy person and amount to 1,493. Thus 1,493 lepers must be added to the above 142, which gives a total of 1,635. In the case of the 1,493 marriages between a healthy and an affected person the fact that in a few instances the healthy individual subsequently became diseased has been neglected, and thus matters will be equalised.

The 1,635 lepers would be replaced by 2,915 children. A few of the children have already died, but as this fact was not consistently enquired into, it will be best to consider them all to be alive. The 1,635 lepers therefore have contributed a permanent addition of 1,280, for 1,635 of the children must be deducted as merely replacing their leprous ancestors. Now it is certain that all the children would not become lepers. At present only 78 of the children are affected, but this small number may be due to the fact that many of them are still young, and it may be reasonably expected that some of them will show manifestations of the disease at a more advanced age. Tables VII and VIII fully justify this suspicion. However, a certain proportion of them are adults and married and have healthy children.

Taking everything into consideration, it is unlikely that more than 5 per cent. of the 2,915 children will become lepers. This would indicate that of the total number of children born up to the present, 145 only are likely to become lepers through the agency of heredity. Hence a leprous population of 1,635 individuals may be expected to transmit the disease to 145. This latter number, as far as the statistical tables show, is too high. It would appear probable from Tables VI, VIII, and XI that about 80 of the children would become lepers through the assumed influence of heredity.

Thus there is no danger of a spread of the pest by hereditary transmission and predisposition. In fact the figures show conclusively that not only could there be no increase to the leper population by means of this agency, but that all other causes being removed, the disease must die out. It is, on the strength of these data, not astonishing to find that the disease should have been practically extirpated amongst a community like the above-mentioned Norwegians, who forsook their own country and wandered into fresh areas and surroundings, apparently out of reach of the factors capable of originating the disease. To this point, however, reference will be made when considering the question of contagion.

TABLE XI.

Children born Before and After Manifestation of Disease in Parent or Parents.

ASYLUM OR LOCALITY.	Children born before appearance of leprosy in parent.	Children born after appearance of disease in parent.	Total number of children.
Agra	52	15	67
Aligarh	30	5	35
Bangalore	52	20	72
Belgaum	7	2	9
Benares	59	5	64
Bombay	201 (11)	10	211
Burdwan	28	5	33
Calcutta	66	12	78
Calicut	28	20	48

NOTE.—The figures in brackets indicate the number of children born before the appearance of the disease in the parent or parents who became lepers: 58 out of a total of 2,447, or 2·3 per cent.

Table XI—continued.

Children born Before and After Manifestation of Disease in Parent or Parents.

ASYLUM OR LOCALITY.	Children born before appearance of leprosy in parent.	Children born after appearance of disease in parent.	Total number of children.
Cawnpore	10	5	15
Conjeeveram	30	12	42
Darjeeling	4	2	6
Dehra Dun	154 (4)	20	174
Delhi	27	6	33
Dharrasala	11	1	12
Fyzabad	16	4	20
Gwalior	8	3	11
Gya	73	5	78
Hyderabad	8	16	24
Jubbulpore	17 (1)	9	26
Jummoo	2	1	3
Kapurthalla	9	3	12
Lucknow	12	1	13
Madras	208 (6)	43	251
Madura	137 (6)	56	193
Mandalay	127 (1)	35	162
Moulmein	15	9	24
Nagpur	265 (2)	30	295

NOTE.—The figures in brackets indicate the number of children born before the appearance of the disease in the parent or parents who become lepers: 58 out of a total of 2,447, or 2·3 per cent.

Table XI—concluded.

Children born Before and After Manifestation of Disease in Parent or Parents.

ASYLUM OR LOCALITY.	Children born before appearance of leprosy in parent.	Children born after appearance of disease in parent.	Total number of children.
Naini and Allahabad	57	17	74
Naini Tal	...	1	1
Patiala	6	1	7
Poona	47 (1)	...	47
Prome	27 (2)	3	30
Purulia	172 (9)	4	176
Rangoon	62	9	71
Rawalpindi	40 (4)	12	52
Sialkot	53	4	57
Subathu	37 (1)	11	48
Tanjore	14 (1)	1	15
Tarn Taran	151 (2)	34	185
Thayetmyo	50 (5)	5	55
Trichinopoly	1 (1)	7	8
Umballa	57	1	58
Yerrowda Prison	17 (1)	3	20
TOTAL	2,447 (58) = 2·3 per cent.	468	2,915

NOTE.—The figures in brackets indicate the number of children born before the appearance of the disease in the parent or parents who become lepers; 58 out of a total of 2,447, or 2·3 per cent.

TABLE XII.

Marriages.

ASYLUM OR LOCALITY.	No. of sterile marriages.	MARRIAGES WITH ISSUES		No. of couples the children of which were born before the appearance of the disease in the parent.	Total number of marriages.
		Between two lepers.	Between a healthy person and a leper.		
Agra	8	...	10	20	38
Aligarh	...	..	3	5	8
Bangalore	9	...	12	22	43
Belgaum	6	...	1	2	9
Benares	4	...	4	19	27
Bombay	72	...	10	100	182
Burdwan	7	...	2	9	18
Calcutta	30	...	7	27	64
Calicut	2	...	12	7	21
Cawnpore	2	...	3	5	10
Conjeevaram	1	...	6	6	13
Darjeeling	...	...	2	...	2
Dehra Dun	15	2	8	46	71
Delhi	2	...	...	7	9
Dharmasala	2	...	1	6	9
Fyzabad	5	...	3	5	13
Gwalior	4	...	1	4	9
Gya	11	...	3	27	41
Hyderabad	5	...	6	2	13
Jubbulpore	1	...	5	5	11
Jummoo	...	...	1	1	2
Kapurthalla	1	1	...	4	6
Lucknow	6	...	...	5	11
Madras	13	1	21	52	87
Madura	18	...	24	32	74
Mandalay	26	...	15	38	79
Moulmein	6	...	5	5	16

Table XII—continued.

Marriages.

ASYLUM OR LOCALITY.	No. of sterile marriages.	MARRIAGES WITH ISSUES		No. of couples the children of which were born before the appearance of the disease in the parent.	Total number of marriages.
		Between two lepers.	Between a healthy person and a leper.		
Nagpur	30	...	17	90	137
Naini and Allahabad	14	...	9	30	53
Naini Tal	...	...	1	...	1
Patiala	3	1	...	3	7
Poona	14	...	...	22	36
Prome	9	...	3	8	20
Purulia	12	...	3	63	78
Rangoon	16	...	6	19	41
Rawalpindi	7	7	2	16	32
Sialkot	14	1	1	21	37
Subatha	26	1	3	13	43
Tanjore	4	...	1	5	10
Tarn Taran	33	12	9	52	106
Thayetmyo	7	...	3	20	30
Trichinopoly	5	...	2	1	8
Umballa	8	...	1	20	29
Yerrowda Prison	3	...	1	6	10
TOTAL	461*	26	227	850	1,564

IX.—Again, the diminished procreative power of lepers and the comparatively high mortality among their offspring operate powerfully against the possible risk of increase in the leper population. The latter point is well established, and Drs. Lewis and Cunningham have drawn attention to it so prominently in their report that it would be useless to enter into any further discussion upon the subject. It may therefore be stated that

* Of these 45 were severally contracted by two persons, both lepers.

a certain number of children born of leprosy parents would be probably shortlived.

There is also no doubt that the reproductive power of lepers is diminished. It is fully established through clinical and pathological observation, that leprosy causes extensive morbid changes in the sexual glands and disturbs the sexual functions. That this applies to men has never been denied. But that it is equally true of women has been proved by Dr. Arning,²¹ who also demonstrated the existence of a leprosy ovaritis. It has been shown from Table IV that the issue of 98 marriages between two lepers amounts to only 65. Again Table XIII shows that of 85 couples no less than 55, or 64.7 per cent., were sterile. Hence, assuming all the 65 children to live and grow up, according to these figures 168 lepers (*cf.* Table XIII) would be replaced by 65 persons, that is, there would be an actual decrease of 62 per cent. in such a population. Assuming that 5 per cent. of the 65 children became lepers, it seems that 168 lepers would be replaced by 3 or 4 lepers, or if the diffusion of the disease depended on heredity only, there would be an actual decrease of almost 99 per cent. in the leprosy population. No doubt these figures are small, yet they allow of the following conclusions:—(a) There is no evidence that marriages among lepers in any way *per se* increase the risk of diffusing the disease, as far as heredity is concerned. (b) Even allowing the latter the fullest play and setting aside all other causes of leprosy, the disease would gradually die out in such a population as has just been considered. Intermarriages, therefore, amongst lepers cannot be regarded as harmful to the community, or as calculated to spread the disease, so far as this depends on hereditary transmission or predisposition.

But how does the case stand when the marriages between a healthy person and a leper are considered? It is more diffi-

(²¹) Journal of the Leprosy Investigation Committee: No. 2, Feb. 1891, page 127.

cult to acquire absolutely accurate information from the data obtainable, and the following statements must be regarded as suggestive only. In almost every instance husbands and wives were healthy at the time of marriage, and one or other contracted the disease some years later. It would evidently not be fair to compare the numbers of children born before, with those born after, the appearance of the disease in either husband or wife, and then draw deductions as to the influence of leprosy on the reproductive power. For, firstly, in a large number of cases one person forsakes the other as soon as the disease becomes marked, and, secondly, by the time the disease manifests itself the age of the patient is often so advanced that the loss of reproductive power may be attributed to organic and functional causes.

Two tables have been prepared (Tables XIV and XIVa) to show how far leprosy may be said to influence the reproductive power of the persons affected. Only such persons have been chosen who cohabited for at least five years after the appearance of the disease, and all patients over forty years of age have been rigorously excluded. In this manner it may be hoped to obtain a few suggestive facts.

In Table XIV such marriages where the husband only was a leper have been grouped together, and it is found that of 296 couples 176, or 59.4 per cent., had no issue after the appearance of the disease in the husband, while the progeny of the 120 non-sterile couples amounted to only 249 individuals. That is, under the assumed conditions, the average number of children to each couple amounts to less than one.

Again from Table XIVa it is seen that of 88 couples where the wives only were affected, no children were born in 62 instances after the manifestation of the disease, the total number of children born to the diseased mothers amounting to 49. Thus 70.4 per cent. of the women became sterile with the appearance of the disease, and the average number of children to each is considerably less than one.

Though these statistics evidently cannot represent the absolute truth, they at least justify the belief in a loss of procreative power causally related to leprosy, and tend to diminish the fear of a diffusion of the disease through marriage with lepers. This is also fully borne out by the history of the leper settlement at Kalawao (Hawaii).²² The latter was established in 1866, and 2,864 persons were consigned there as lepers from that time to 1884. At the end of this period of eighteen years, 26 children survived who had been born at the settlement of leper parents, and only two of these 26 were lepers.

From all these considerations then it may fairly be concluded that marriages among lepers, and with lepers, do not increase the risk of a diffusion of leprosy by means of the offspring, and that this to a great extent is due to the relative sterility of lepers, whether males or females.

TABLE XIII.

Table showing the Fertility of Leprous Couples (both Husbands and Wives being Lepers).

NAMES OF ASYLUM, ETC.	No. of leper couples.	No. of such without any issue.	REMARKS.
Almora	9	4	A leper woman married twice.
Belgaum	1	1	
Bombay	3	3	
Dehra Dun	4	2	In one case a child was born who died as an infant. No children since.
Kapurthala	2	1	A leper woman married twice.
Lucknow	2	2	
Madras	1	...	

(²²) Report of Dr. Fitch: Appendix to Report on Leprosy in Hawaii, 1886, page xxxi.

Table XIII—continued.

Table showing the Fertility of Leprous Couples (both Husbands and Wives being Lepers).

NAMES OF ASYLUM, ETC.	No. of leper couples.	No. of such without any issue.	REMARKS.
Mandalay	1	1	
Meerut	6	6	
Nagpur	1	1	
Patiala	1	...	
Rangoon	1	1	
Rawalpindi	14	7	
Sialkot	14	13	
Subathu	2	1	
Tam Taran	22	11	
Umballa	1	1	
TOTAL	85 = 168 persons.	55 = 64.7 per cent.	

TABLE XIV

To show the Relative Sterility of Couples where the Husband is a Leper and the Wife Healthy.

ASYLUM OR LOCALITY.	Total number of such couples.	No. of those which are sterile.	No. of those which have children.	No. of children.
Agra	12	2	10	15
Aligarh	3	...	3	5
Almora	4	3	1	3
Bangalore	14	6	8	14
Benares	3	...	3	4
Bombay	7	7	...	...

Table XIV—continued.

To show the Relative Sterility of Couples where the Husband is a Leper and the Wife Healthy.

ASYLUM OR LOCALITY.	Total number of such couples.	No. of those which are sterile.	No. of those which have children.	No. of children.
Burdwan	4	3	1	2
Calcutta	11	8	3	6
Calicut	10	2	8	16
Cawnpore	5	4	1	2
Conjeeveram	9	4	5	10
Darjeeling	1	...	1	1
Dehra Dun	5	1	4	7
Delhi	2	2	...	...
Fyzal ad	5	2	3	4
Gwalior	5	4	1	3
Gya	9	7	2	2
Hyderabad	9	5	4	11
Jubbulpore	5	1	4	8
Lucknow	2	2	...	...
Madras	27	17	10	24
Madura	32	16	16	44
Mandalay	19	12	7	12
Moulmein	3	...	3	7
Nagpur	25	21	4	11
Naini and Allahabad	15	10	5	10
Prome	9	6	3	6
Purulia	12	12	...	...
Rangoon	6	6	...	...
Sialkot	1	...	1	1
Subathu	3	1	2	5
Tanjore	3	2	1	1
Tarn Taran	6	2	4	8
Thayetmyo	5	4	1	1
Trichinopoly	5	4	1	6
TOTAL	296	176 = 59.4 per cent.	120	249

TABLE XIVa.

Table to show the Relative Sterility of Couples where the Wife is a Leper and the Husband Healthy.

ASYLUM OR LOCALITY.	Total number of such couples.	No. of those which are sterile.	No. of those which have children.	No. of children.
Almora	2	1	1	1
Bangalore	9	6	3	5
Bombay	6	5	1	1
Calcutta	9	6	3	4
Cawnpore	1	...	1	1
Conjeeveram	1	1	...	...
Darjeeling	1	...	1	1
Dehra Dun	3	3	...	...
Deihi	1	...	1	6
Gya	1	1	...	...
Hyderabad	1	...	1	3
Madras	7	4	3	4
Madura	8	6	2	3
Mandalay	8	4	4	10
Moulmein	1	1	...	...
Nagpur	13	11	2	6
Purulia	6	6	...	...
Rangoon	1	...	...	...
Rawalpindi	1	...	1	1
Tanjore	2	2	...	...
Tarn Taran	5	3	2	3
Umballa	1	1	...	...
TOTAL	88	62 = 70.4 per cent.	26	49

Summary.

The Commissioners have thus come to the conclusion that there is no evidence that leprosy in India is transmitted through heredity from parent to child, their reasons being—

- (1) no authentic congenital case has ever been put on record, nor was one seen in this country;
- (2) true family histories of leprosy could be obtained in only 5 or 6 per cent. of the cases;
- (3) many instances occur of children being affected while their parents remain perfectly healthy;
- (4) the percentage of children, the result of leper marriages, who become lepers is too small to warrant the belief in the hereditary transmission of the disease;
- (5) the facts obtained from the Orphanage at the Almora Asylum disprove the existence of a specific hereditary predisposition;
- (6) only 5 or 6 per cent. of the children born after the manifestation of the disease in the parents become subsequently affected;
- (7) the histories of the brothers and sisters of leper patients with a true or false hereditary taint seem to show that little importance can be attached to inheritance as an agent in the perpetuation of the disease.

For the same reasons it may be assumed that the specific hereditary predisposition to leprosy is but slight and practically does not exist.

Lastly, it has been shown that taking all the information obtainable and even allowing the fullest influence to heredity, there appears to be no risk of an increase to the leper population of India, so far as the disease is dependent on heredity for its multiplication, and that marriages with, or intermarriages between, lepers cannot be regarded in the light of a danger to the community.

CHAPTER V.

Contagiousness of Leprosy.

ALL modern authorities are agreed that leprosy is an infective disease, that is, one caused by a microbe, the bacillus lepræ, which obtains access to the body from without, and subsequently multiplies within the organism, calling forth the characteristic lesions. The next point to be decided is whether or no leprosy is *contagious*.

It is only too frequently taken for granted that a disease due to a pathogenic germ is necessarily also contagious. That this need not be the case will be shown later on. Here it may suffice to recall to mind two instances of infective diseases which are by no means contagious, *viz.*, malaria and pneumonia.

With regard to the contagiousness of leprosy, the views of authors are highly conflicting, and a brief allusion will be made to the statements of some of them. These matters have, during the last few years, been so much before the world that this reference need only be very brief. Flügge¹ says: "the diffusion of leprosy by contagion is *exceedingly rare* and evidently can only take place *under special and predisposing favourable conditions*" (the italics are not Flügge's). Now it may be mentioned at once, as this will guide subsequent arguments, that the more weight is attached to special favourable conditions, in fact what in clinical language is called "the suitable nidus," the further contagion disappears into the background. Indeed, for all practical purposes—and these are what the legislator or sanitary reformer has to consider—it vanishes altogether.

Hansen,² on the other hand, is a contagionist, and expresses

(¹) C. Flügge: Die Mikroorganismen. Leipzig, 1896, page 221.

(²) A. Hansen: Journal of the Leprosy Investigation Committee, No. 2, and Lancet, June 28, 1880, page 1431.

himself thus: "I do not know the way in which leprosy is communicated or transferred from a leper to a sound person, but I am most inclined to believe that it is done by a sort of inoculation, that there is wanted a very intimate intercourse and some defect in the integument of the infected." Now, in the chapter on Heredity mention has been made of Hansen's researches in America. And it seems strange that he should consider the fate of the emigrated Norwegian lepers an absolute proof against an hereditary transmission of the disease, while he is unwilling to allow that the same argument applies *à fortiori* against contagion. How is the fact to be explained that in a community of one hundred and sixty lepers the disease should die out amongst their descendants, without altogether disbelieving in contagion, or attaching to it a nominal importance? In fact Hansen's facts seem to disprove the theory of contagiousness much more forcibly than that of hereditary predisposition.

Leloir,³ who is also a contagionist, defends his views in the following words: "Mais comme l'a bien dit le docteur Vidal le 13 octobre 1885 à l'Académie de médecine, il faut remarquer que beaucoup de maladies dont la transmission par voie d'inoculation n'est plus niée aujourd'hui présentent souvent des inoculations difficiles, irrégulières telles la varicelle, la diphthérie, telle la tuberculose, etc. On pourrait ajouter à la liste des affections le lupus, l'érysipèle lui-même." This statement challenges some comment. Firstly, there can be no doubt as to the ease with which diphtheria and erysipelas can be inoculated, and it is a well-established clinical fact that these two diseases spread *par excellence* through contagion. Very few would venture to place them in the same category with leprosy, and attempt to establish any analogy between them and the latter. Secondly, if the contagiousness of leprosy is

(³) H. Leloir: *Traité Pratique et Théorique de la Lèpre*. Paris, 1886, page 301.

no greater than that of lupus or tuberculosis, the whole matter will be reduced to a question of abstract scientific interest, and is thereby at once removed from the sphere of the legislator, in so far as such strong measures as segregation and social interference are concerned. No one would ever think of enforcing such measures for lupus or tuberculosis.

Lastly, reference must be made to Virchow,⁴ who, in 1859, was asked by the Norwegian Government to investigate the disease in their country, and examined hundreds of cases. He sums up his views on contagion as follows: "Therefore all we can say is, that all cases of supposed contagion or inoculation brought forward may be explained in various ways, and moreover are so rare that as far as the general ætiology of the disease is concerned they may in any case be disregarded." Practically, leprosy, according to him, does not spread by contagion, though it may scientifically be correct to classify it amongst the contagious diseases. This point will be further considered in another place.

Before giving a detailed account of the views held by the Commissioners, it will be necessary to make a few general remarks on some points which should guide the enquirer in a similar research, and also to criticise the forms of argument used by many authors. The importance of the subject will excuse this digression.

Firstly, when the question of contagion is under consideration, it is of the utmost importance to separate the abstract and scientific meaning of the term contagion from the practical one. It is not sufficient to determine by experiment, or on the evidence of one or two authentic clinical cases, that a disease is infective and contagious, but a careful enquiry must be made into the part played by contagion under ordinary surroundings and practical conditions.

Secondly, the connotation of the term infection must not

(⁴) R. Virchow: *Krankhafte Geschwülste*, Vol. II, page 507.

be misconstrued or unduly extended. Bacteriological and laboratory researches have certainly contributed much to the knowledge of the ætiology of many diseases, but the actual question of contagion cannot be settled in this way. Clinical and epidemiological evidence is of the greatest importance.

To elucidate these points, let it be supposed that a disease is known to be an infective one. When it is acknowledged that a disease is infective, all that is asserted is, that "the disease may be transmitted from the affected to the healthy individual," but this premises nothing as to the natural mode of diffusion of the disease in question, and whether, or to what extent, under ordinary practical conditions, such transmission does take place. "The natural mode of transmission of an infective disease depends on the faculty pathogenic germs possess of leaving the body of the diseased in the full possession of their power of setting up an infection. If they be thrown off from any surface of a diseased organism in sufficient quantity, and in a sufficiently resistant state, a transmission of the disease from the affected to the healthy person *may* take place, and the diffusion of the disease in such cases, under certain conditions, *may* be effected through contagion.* If, however, the pathogenic germs reproduced in the body of the diseased person never leave the latter, or only do so without possessing the power of causing subsequent infection, the infective disease caused by such germs is non-contagious. The germs in such cases must have a place somewhere, whence they can always *de novo* attack the healthy organism."⁶

Amongst the infective contagious diseases remarkable differences exist as to the degree of contagiousness, depending partly on the unequal liability of the healthy body to be invaded by germs, and partly on the resistance and quantity of

* If, however, the germs or their spores already are, or become, widely distributed throughout space, the risk of contagion may be disregarded as compared with the *de novo* acquisition of the disease.

(⁶) C. Flügge loc. cit. and also Flügge: Grundriss der Hygiene, page 466.

germs leaving the diseased body. Again, the paths by which the microbes can enter may be such as only in rare cases permit of their establishing themselves within the tissues, and finally, the human body may possess certain protective means which offer great obstacles to the attacking germ.

A disease may thus scientifically be grouped amongst the infective and contagious diseases, and yet practically and clinically hardly deserve this name. It is to be regretted that the modern advances of bacteriology and animal inoculations have tended to make not only the public, but also scientific writers, disregard the evidence derived from clinical and epidemiological experience. Without, for a moment, under-estimating the importance of bacteriological and animal experiments, it is necessary to guard against taking a one-sided view of the matter, a tendency to which, in these times, has often been only too manifest. Experimenting, as the bacteriologist generally does, on highly susceptible animals, he easily runs the risk of arguing beyond his premises, and of drawing conclusions from his experiments which he applies without sufficient reserve to the natural mode of infection. It is quite impossible to deduce the ætiology of an infective disease from bacteriology alone; clinical and epidemiological observations carefully made must always be taken into account. A susceptible animal may easily be infected by experiment, and yet the case may be quite different with man.

The best example to elucidate this point will be found in tuberculosis. The researches of Koch have shown that this disease is not only infective but also contagious. It is, however, equally certain that in the ordinary human surroundings the conditions necessary for the multiplication and proliferation of the tubercle bacilli *never* exist. The diffusion of the disease depends thus, firstly, on its transmission from one individual to another, and, secondly, on the fact that the bacilli may remain dormant, in the full possession of their virulent properties, for a considerable time, without, however, as was just mentioned,

showing any signs of proliferation. They are in fact true parasites. Animals, such as guinea-pigs, are infected with the greatest ease. Again, the tubercle bacillus, as Cornet⁶ has shown, is widely distributed throughout space without any loss of vigour. *A priori* one would be inclined to assume that tuberculosis must be a highly contagious disease. But experience teaches beyond doubt that of healthy individuals living in the immediate neighbourhood of phthisical patients, by no means all become affected; "in fact perhaps only slightly more than would become affected if the opportunity for infection were less."⁷ The *disposition* of an individual is of the highest importance in bringing about a tubercular infection. In fact, as Flügge says, "the disposition actually governs the mode of diffusion of tuberculosis." And that in tuberculosis the danger of infection is so small is chiefly explained by the fact that the existence of the bacillus, and its introduction into the human body, are not sufficient to bring about the infection without the necessary individual disposition.

The causes and nature of such disposition may be unknown, but that it exists no one denies, and its bearing on contagion is evident. The experiments of Monti, Leo, Charrin, Roger, and E. Klein⁸ have thrown much light on the nature of disposition and susceptibility. These will be more fully alluded to in Chapter VI. The greater the prominence given to this disposition, the less the absolute influence of contagion becomes. We notice the best example of an individual disposition in tuberculosis, where the greater or smaller collection of resistant germs around the human body has, as we know from experience, a subordinate importance in the diffusion of the disease. It has become an almost general practice in tuberculosis to counteract

(⁶) G. Cornet: Ueber Tuberculose. Leipzig; and footnote on page 287.

(⁷) C. Flügge: loc. cit., page 219.

(⁸) Nineteenth Annual Report of the Local Government Board, 1889-90, Supplement, page 217.

nearly exclusively this individual disposition, and not, as with other infective diseases, aim at a careful removal of the pathogenic germs."⁹

Keeping these points in mind the nature of the contagiousness of leprosy will be discussed from a clinical point of view, and the results gained from bacteriological work will be given in the Laboratory Report. The evidence collected by the Commissioners during their stay in India can, in the first instance, only apply to this empire. They have come to the following conclusion, that *though they consider leprosy an infective disease, caused by a specific bacillus, and moreover also a contagious disease, they are of opinion that there is not sufficient evidence that leprosy is maintained or diffused by contagion; indeed under the ordinary human surroundings the amount of contagion which exists is so small that it may be disregarded, and no legislation is called for on the lines either of segregation, or of interdiction of marriages with lepers.*

It would be useless in an enquiry of this nature to take the word of the native inhabitants. That the native ordinarily does not fear the disease may be easily gathered from the fact that in bazaars leprosy vendors are not rarely found selling food or sweets. Again, however unclean the natives may consider a leper, as long as he is in the possession of money, he is almost always welcome. The readiness also with which the native police and their officials handled lepers brought up for inspection before the Commissioners was very noticeable. There are of course differences in this respect in the various parts of India, and the Commissioners can only speak with confidence of the places visited. This, however, has already been discussed in another chapter. It has all along struck the Commission that though a native on being questioned will, as a rule, state that leprosy is a contagious disease, yet his own acts do not support his statements.

(⁹) C. Flügge: loc. cit., page 614.

Neither would it be permissible to be too much guided by the opinions of medical observers in India. The leper, not really being such an outcast or deplorable individual as European opinion considers him to be, is seldom seen in the dispensaries, preferring to haunt bazaars or other crowded places to beg. Most Civil Surgeons have not much opportunity, therefore, of studying the ætiology of this disease, with the exception of such of them as happen to have large asylums under their jurisdiction. Moreover, the knowledge that no treatment of an outdoor nature is of any service in these cases prevents Civil Surgeons from encouraging their attendance.

The Commission have only been guided by facts obtained by themselves. From these they deduce the following arguments against a contagion which they deem worthy of a practical consideration.

I. All the cases brought forward and demonstrated to the Commissioners as instances of contagion have broken down with one possible exception. These, as a rule, concerned hospital or asylum servants. A list of these cases is appended at the end of this chapter (Table I). Now it seems very significant that the cases which were supposed to prove the contagion theory, and on which such theory was really based, almost entirely collapsed.

II. In not a single case could contagion, or the possibility of contagion, be actually demonstrated in a manner free from objection. The native leper, in an overwhelming majority of instances, offers no suggestion as to the contraction of his disease; denies that he has ever had any contact or intercourse with lepers, and simply accuses fate. Occasionally they mentioned that for some time they had eaten with lepers, but their stories were in most instances too extravagant for belief. For instance, a patient who had been a sailor, says that while in Demerara, a leper used to visit his ship, and all the crew used to smoke the same hookah with this leper. Two years later this man contracted leprosy. Similar stories are not rare, but

they certainly cannot be regarded seriously. In other cases a man will relate that many years ago he came into contact with a leper. Such statements have led some authors to assume a long incubation period for the disease. Now it may be questioned whether it is still possible to talk of contagion after an incubation period, which, in many instances, must have extended over ten or more years. Whatever view may be taken of this matter, the assumption of an irrationally and disproportionately long latent period is certainly a weak point in any theory of contagion. And it becomes still weaker when it is considered that, in the case of leprosy the people who presumably have been exposed to the risk of contagion during this "long incubation period," have lived in an endemic area.

Special attention was paid by the Commission to the effect of people eating with lepers. Table V, at the end of this chapter, shows that seventy-nine lepers ate and drank for some time out of the same vessels with two hundred and five healthy people, and of the latter 7 per cent. afterwards became lepers (Table V). Now these cases all occurred in families. But it has been shown in Chapter III that leprosy has a tendency to appear in families, though the cause of this is not a specific hereditary transmission, nor an hereditary predisposition, but most likely explicable by the fact that the members of a family are more likely to be subjected to the same abiding external causes. But in any case the figures obtained from Table V do not permit a great influence to be conceded to contagion, even if the instances of possible contagion were quite free from all objection.

III. In a family contagion has of course the widest play. However, it has been found that the disease does not spread sufficiently amongst the members of one family to warrant the conclusion that it is contagious to any extent. Table II shows that an assumed contagion could be traced in only 5 per cent.

IV. Again, when the intimate intercourse between man and wife is considered, it is astonishing how seldom the wife

"catches" the disease from her husband, or *vice versa*. Yet it is well known that bacilli may easily be found in the spermatic fluid,¹⁰ and here then there is an opportunity offered for oft-repeated inoculation through the mucous membrane of the genital tract. Yet a case is hardly ever found where *bona fide* the disease may be assumed to have spread from husband to wife (Tables III and IIIa).

V. Next, vaccination has been mentioned as affording a risk of diffusing leprosy. This statement is not borne out by facts ascertained in India. Firstly, the number of persons actually vaccinated in India is very small in comparison with the general population. Taking the total number of people in Bengal, North-Western Provinces and Oudh, Punjab, Central Provinces, Berar, Lower Burma, Assam, Madras, Bombay, and Coorg, it appears that in the year 1889 of 7,985,543 children available for vaccination only 2,178,464, or 27.2 per cent. were vaccinated.¹¹ Secondly, a considerable number of these were vaccinated from the calf. Thirdly, where arm-to-arm vaccination is practised, lymph is taken from the vaccinifer at an age when leprosy rarely occurs. Fourthly, the experimental evidence of the Norwegian doctors, quoted by Leloir, seems to indicate that it is highly questionable whether such inoculation, as vaccination implies, would be able to produce the disease in another person, even granted that the vaccinifer were a leper, and that the lymph contained bacilli. Lastly, as will be seen more fully from the Laboratory Report, three of the Commissioners vaccinated a number of lepers over healthy and affected areas, and subsequently examined the lymph for the characteristic bacilli. In no case were undoubted leprosy bacilli found, either in the lymph or crusts; of ninety-

(¹⁰) Nature, Origin, Transmissibility, the Methods of Propagation and Transmission of Leprosy, by M. E. Besnier. Translated by Surgeon-Major O. Baker, Calcutta, 1889, pages 8 and 10.

(¹¹) Twenty-sixth Annual Report of the Sanitary Commissioner with the Government of India, 1889. Appendix to Section VII, page 164.

three specimens only six were slightly suspicious (Table VI at the end of this chapter). It has been ascertained by experiment (Laboratory Reports) that if a blister be raised over apparently healthy skin, its serous fluid will be quite free from the bacilli, while in blisters raised over leprosy nodules, bacilli may in some cases be found. And surely no one would ever think of vaccinating an individual over a tubercle or diseased part, or if he did so, would employ such lymph to vaccinate another individual. The practical danger, therefore, of leprosy being diffused in this manner, even supposing the disease to be highly contagious, is minimal. The instances quoted in literature of leprosy being "vaccinated" on to a healthy child are too equivocal and ambiguous to carry much weight.¹²

Dr. Arning,¹³ who obtained more positive results and found bacilli in the vaccine lymph, states distinctly that he obtained bacilli only in cases of extensive cutaneous leprosy. The latter fact removes at once all fear, because all vaccinators would have some hesitation in vaccinating from such a person. Surgeon-Major Oswald Baker's results,¹⁴ on the other hand, fully agree with those of the Commission, although, in his vaccination experiments, he selected sites solely with reference to the presence of characteristic patches of leprosy. From what has been said it is evident that practically there is no risk of a diffusion of the disease in vaccination from arm to arm.

VI. Attempts were made to enquire into the possibility of a leprosy community becoming or acting as a centre whence the pest might be diffused amongst the population. A research of this nature is obviously connected with great difficulties in a vast country like India.

(¹²) W. T. Gairdner, Brit. Med. Journ., 1887; and Daubier, Monatschr. f. prakt. Dermat. 1889.

(¹³) Journal of the Leprosy Investigation Committee, No. 2, Feb. 1891, page 131.

(¹⁴) Nature, Origin, Transmissibility, etc., of Leprosy, by M. E. Besnier. Translated by Surgeon-Major O. Baker, page 4.

The census returns present strong arguments against such a spread of leprosy, since the ratio figures remain more or less unchanged. An absolute value, however, cannot be attached to these figures, as here the diagnostic powers of laymen and the inaccurate statements of natives are liable to mislead an enquirer. Nevertheless census returns do possess a high relative value, especially if, as in the present instance, opportunities are offered of comparing the statistics of three decennial periods. On these points reference must be made to Chapter III of this report.

Tarn Taran allows valuable deductions to be drawn as to the risk of the spread of disease around a leprosy community. A quarter of the town, in absolute continuity with the rest, is kept apart for, and inhabited solely by, lepers. This condition of things, however, has not caused a diffusion of the disease among the healthy population, the number of lepers remaining more or less stationary, or, at least, never increasing beyond the original ratio. Nor has any diffusion, even to the immediate neighbourhood of the leper quarter, ever been known to occur. Lepers wander to Tarn Taran to bathe in its holy tank, which is supposed to possess special healing powers, and thus the number of lepers is always maintained. But the disease is not especially prevalent amongst the people of the district, and though this leper quarter has existed for many years, the disease has not increased amongst the original inhabitants. For the figures in support of this statement, reference should be made to Chapter III, where this point is specially discussed.

Unfortunately on account of insufficient data this line of argument cannot be followed out. But it may be remarked and taken for what it is worth, that it is an almost universal opinion of scientific and intelligent men in India that a spread of the disease has never been known to take place from a leper centre to its neighbourhood.¹⁰

(¹⁰) Cf. Chapter II: Belgaum and Bombay.

VII. It is believed in some parts of India, especially in the hill tracts, that those who go barefoot are liable to be directly inoculated with leprosy through wounds or ulcers of the feet. In one station in Burma, visited by the Commissioners, they were informed that leprosy had spread among the members of a school after lepers had been in the habit of walking about the compound. As, however, an examination of some of the supposed lepers in this school showed that several of them were not suffering from this disease, this statement was considered open to doubt.

At Almora an opportunity occurred of examining the paths and banks in the asylum compound, on which the lepers were in the habit of walking and sitting. One hundred cover-glasses were prepared from earth taken from these sites, and only ten leprosy bacilli were found in the whole number of specimens. But at present no criterion of a living leprosy bacillus exists, and in any case the small number found in an extended series of observations, on the most favourable material, would suggest that the danger of individual inoculation is possible, but that the risk of the diffusion of the disease in this manner is very slight. On the other hand, it is noteworthy that an examination of dust from huts inhabited by lepers suffering from the tubercular and anæsthetic types of the disease, and afflicted with ulcers on their feet and hands, confirmed the observation of Kaurin,¹⁶ who has not succeeded in finding bacilli in the earth, dust or air in the rooms of lepers (Table VII).

VIII. This chapter may be concluded by stating that the Commissioners during their enquiries met with many cases where people, either voluntarily or for various reasons, lived in asylums with lepers, often eating and drinking with them, or smoking with them, perhaps attending to their wants and ailments, and yet remained perfectly untainted, often after many

(¹⁶) Kaurin: Journal of the Leprosy Investigation Committee, No. 2, Feb. 1891, page 68.

years of such association. The value of such instances may be questionable as evidence against contagion, being entirely on the negative side, still they are highly instructive in throwing light on the practical dangers of contagion, and until an actual positive case, free from all objection, is published, increase in worth. Such an absolutely positive case so far is not known, as a perusal of the Journal of the Leprosy Investigation Committee will show. In the absence of such information, it is permissible to deny the practical possibility of the spread of leprosy by contagion. A case can only be positive, if it answers all the conditions postulated by Virchow: "It must be an observation made with the full assurance and every guarantee of certainty." A study of Tables IV and IVa will show that of one hundred and four persons living with lepers in asylums, under the most favourable conditions for contracting a communicable disease, only one, or possibly two, became lepers (1 or 2 per cent.).

Summary.—In coming to the conclusion that, as far as practical conditions and surroundings are concerned, the danger of leprosy being diffused and spread by contagion is exceedingly small, arguments have been used which do not possess the character of novelty. India, however, offers no other, and since extended and numerous experiments obviously cannot be made on man, and knowledge gained from animal inoculations cannot be entirely relevant, deductions can only be drawn from clinical evidence. This clinical evidence, for India at any rate, is strongly against a measurable contagiousness of leprosy. It is in fact with leprosy exactly as with tuberculosis, and all that has been said about the latter affection may be applied equally to the disease which forms the subject of the present enquiry.

In leprosy, therefore, the disposition of the individual plays an important part, just as it does in phthisis. With the assumption of such disposition the practical importance of contagion is reduced to a minimum, and it becomes the duty of the reformer to find means to prevent and counteract this dispos-

ition. With the discovery of the bacillus lepræ by Hansen the infective nature of the disease has been finally established, and subsequent experiments have also shown that in the scientific sense of the word the disease must be classed amongst the contagious diseases as defined above. But these facts must not obscure all other evidence, and it must not be forgotten that contagion is but a relative term, and that where reforms and similar measures are under consideration, the actual and concrete influence of contagion is the factor to be considered. This, however, has been shown to be as small as, or even rather less than, in the case of tuberculosis.

APPENDIX TO CHAPTER V.

Several tables, with some necessary comments, will now be given to illustrate the arguments used in the previous pages.

TABLE I.

Cases brought forward in Proof of the Contagiousness of Leprosy.

(1) *Agra*.—One of the dressers whose duty it was to rub gurjun oil into the skin of lepers was said to have developed leprosy in consequence. The hospital assistant, however, without being asked, volunteered the statement that this dresser was a leper before he commenced his duties.

(2) *Ajodhya*.—A woman was supposed to have caught the disease from her husband. On visiting her in her own home it became evident that she was not even a leper, but had suffered from paronychia of the thumb of one hand which had led to a slight deformity of the nail and ungual phalanx.

(3) *Bombay*.—(a) A patient in the Trombay Asylum emigrated to Mauritius, and returned to India in 1884 with swelling of the eyebrows and black patches on the cheeks. When this asylum was opened in 1885 he began work as a ward boy, and continued in that capacity until a year ago, when signs of leprosy became so marked that he became a patient in the asylum.

(b) A student in Bombay, while making an autopsy on a leper, pricked his hand. A short time afterwards he suffered from fever, and the hand became inflamed and swollen. Pain and thickening in the course of the ulnar nerve followed, and later there was wasting of the muscles supplied by this nerve together with anæsthesia over the area supplied by it. Similar nerve symptoms then occurred on the opposite side, and the patient suffered from pain in the region of the heart. He was under treatment for some time, and the symptoms all disappeared. Shooting pains in the course of the ulnar nerves recurred during some months, but eventually disappeared again and he remained quite well. At no time did any discoloured anæsthetic patches occur on the body, and the anæsthesia and wasting were confined to the distribution of the ulnar nerve.

This history clearly points to a neuritis set up by septic infection, which subsided under treatment. Yet the case when it first occurred was quoted as an example of the inoculability of leprosy.

(4) *Calicut*.—The patient had been a sweeper at the asylum for twenty-three years. In this capacity he also had to dress the worst ulcers. He used

to mix freely with the lepers and eat what they left. According to his own assertions he was quite well twenty-three years ago and developed leprosy only two years ago. He belonged to Calicut and was of a very low caste. His father was not a leper, and this was confirmed by the cook of the asylum, who had resided there for thirty years. The father had been a sweeper for six years, his son succeeding him on his death. The patient's mother, and his six brothers and sisters, were all healthy. An old inmate of the asylum, on the other hand, asserted that the sweeper had suffered from leprosy for at least six years, but was apparently healthy twenty years ago.

This case is the only one quoted in support of contagion which has not utterly broken down, and whatever value it possesses in the way of positive evidence must be conceded.

(5) *Madras*.—The cook of the asylum had been employed for fifteen years, and was suffering from incipient leprosy. He had a discoloured and anæsthetic patch over the right knee, and a similar patch on the right side of his face. He asserted that these changes were of six months' standing, and denied all family history of leprosy.

On making enquiries of an old patient (an intelligent Eurasian and a pupil teacher), it was found that the patch in the face existed before the cook came to the asylum; moreover, at that time he attended as an out-patient and was treated with gurjun oil. Without the knowledge of the patient his brother was interrogated, and he assured the Commissioners that the patch on the face had existed over fifteen years, and that their mother, another brother, and one of the sister's sons also were lepers. This witness had always considered his brother to be a leper.

It is quite clear that this case is valueless as an instance of contagion.

(6) *Tanjore*.—A Hindu, aged 45, who had suffered from leprosy for ten years, stated that his wife had lately become a leper. He had constantly lived with her. The Commission visited the latter at her house and found on examination that she complained of a feeling in the soles of her feet as though she were walking on wool. She had no anæsthesia or patches, and was certainly not a leper.

(7) *Trichinopoly*.—A patient in the asylum stated that he suffered from a skin eruption eleven years ago. He wished to be admitted into the asylum as a patient, but admission was refused as the disease was too slight. He was employed as a ward cooly, and used to dress the lepers' ulcers. He contradicted himself as to dates, but was certain that the disease appeared after he joined the asylum.

On referring to the records of the asylum it was found that the patient "was admitted as a leper on the 25th of March, 1880, and discharged on the 17th May, 1880," when he was said to be cured. Further it was found in the letter book of the asylum that the patient commenced his duties as ward cooly

in July, 1882, during the absence on leave of the former ward cooly. This man, who happened to be in Trichinopoly, was questioned separately and without his having had any communication with the patient. He stated that when he returned from leave he threw up the appointment, and the patient was confirmed in it. Three years later the leprosy became more marked, and he was placed on the asylum register as a patient.

In this case the statement of the patient, that he contracted leprosy after he became an attendant at the asylum, was clearly disproved by the evidence of the asylum records and that of his predecessor in office.

The above eight examples illustrate very clearly the class of cases usually adduced to prove the contagiousness of leprosy. The cases at Madras, Agra, Trombay, Calicut, and Trichinopoly all relate to persons employed, at one time or other, in the asylums. At Ajodhya and Tanjore the evidence offered is that of husband and wife, while at Bombay the case quoted is that of a student who accidentally infected himself during an autopsy on a leper. For the details of the last case the Commissioners are indebted to Surgeon-Major Hatch of Bombay. The case was published when it first occurred, and was widely quoted as an example of the inoculability of leprosy.¹⁷ The first symptoms, indeed, were very suspicious, but the Commission are of opinion that the further progress of the case, as related by Dr. Hatch, entirely negatived the original diagnosis of leprosy. Besides, it is well known that infective processes are not unfrequently followed by peripheral and central nervous changes.

In the two cases in which the wife was supposed to have contracted leprosy from the husband, an examination showed that the woman was not a leper at all, while in four out of five cases in which asylum attendants were supposed to have been infected by the inmates, the former were shown to have been lepers before they entered on their duties.

Thus the Calicut case alone remains. But the statement of the patient himself and that of the old inmate of the asylum

(¹⁷) *Lancet*, May 17, 1890, page 1064.

are considerably at variance as to dates. And it must always be remembered that in a country like India, where leprosy is endemic, it is quite possible that the patient may have acquired the disease from some source other than the asylum: in other words, that the case may have been merely a coincidence.

TABLE II.

Table showing in how many Instances the Disease may be said to "have spread" from one Member of a Family to Another.

NAME OF ASYLUM, ETC.	No. of lepers.	No. of people living with them.	No. of such people affected.	REMARKS.
Agra	28	55	4	One case is doubtful.
Aligarh	5	19	...	
Almora	39	86	8	In one case the disease appeared sixteen years after the death of the leper.
Bangalore	4	15	2	One case doubtful.
Benares	10	34	...	
Bombay	60	105	8	
Burdwan	12	37	...	
Calcutta	40	67	2	
Calicut	13	43	...	
Cawnpore	8	20	...	
Conjeeveram	13	40	2	
Darjeeling	2	8	...	
Dehra Dun	44	116	11	Of these two became lepers many years after the death of the leper they came in contact with.
Delhi	5	18	...	
Fyzabad	7	20	...	
Gwalior	2	9	...	
Gya	16	46	1	
Hyderabad	7	12	...	
Jubbulpore	8	22	...	

Table II—continued.

Table showing in how many instances the Disease may be said to
"have spread" from one Member of a Family to Another.

NAME OF ASYLUM, ETC.	No. of lepers.	No. of people living with them.	No. of such people affected.	REMARKS.
Jummoo . . .	1	3	...	
Kapurthalla . . .	2	2	1 ✓	This case is very doubtful.
Lucknow . . .	5	6	...	
Madras . . .	60	156	17	Five cases doubtful.
Madura . . .	5	21	...	
Mandalay . . .	79	205	4	In one case the child acquired the disease at the same time as the father.
Moulmein . . .	9	14	2	These cases are both doubtful.
Nagpur . . .	67	166	3	
Naini and Allahabad . . .	6	14	...	
Patiala . . .	1	2	1	
Prome . . .	20	62	4	One case doubtful.
Purulia . . .	25	53	11	Ditto.
Rangoon . . .	20	33	1	
Rawalpindi . . .	9	19	...	
Sialkot . . .	1	3	...	
Subathu . . .	5	14	...	
Tanjore . . .	7	16	2	These two cases are doubtful.
Tarn Taran . . .	37	53	4	
Thayetmyo . . .	24	51	7	Three cases are doubtful.
Trichinopoly . . .	6	6	...	
Umballa . . .	7	20	...	
TOTAL . . .	719	1,691	95	Diagnosis doubtful in seventeen cases.

In the construction of this table only those cases have been chosen where it was stated that the members of the

respective families lived together. In many instances no special notice had been taken of this fact, and all these have been disregarded unless a case of leprosy occurred amongst the children. Now, no doubt, as in many of the cases left out on account of insufficient details there has been no separation or segregation of the leper, this table will over-rate the chances of a possible contagion rather than under-estimate it. It will be seen that about 5 per cent. of the persons living in daily intercourse with lepers under the same roof at one time or other developed the disease. A number of children have been left out of consideration because they died as infants or while very young. This has been done in order to give the argument in favour of contagion every possible advantage, for surely, where contagion as such is discussed, age need hardly be considered. If a disease be contagious it should be so at any age. But if it is necessary to assume a long incubation period, as many writers do, which sometimes extends through infancy and childhood, until what is called the probable age of attack is reached, this is surely an unjustifiable extension of the term contagion, or a practical denial of the influence of contagion by a reduction to an absurdity. Again, in some cases entered in the table, the diagnosis of leprosy was extremely doubtful, and in one case the child contracted the disease at the same time as the father. Thus by allowing the validity of these cases a further advantage is allowed to the hypothesis of contagion. And yet in only 5 per cent. of the cases could a possible influence be assumed.

But the ratio obtained from this table of course cannot be taken to represent the actually existing chances of infection. For from among the total community coming into contact with lepers, only a few have been selected. Moreover all other causes, such as endemicity, or a *de novo* origin of the disease, have been altogether disregarded. However, assuming, for argument's sake, that all the above cases are genuine instances of contagion, and that the spread of leprosy depends on this

alone, a little reflection will show that, selecting such a community as is implied in the tables, the disease would die out after a few generations. Has this not been entirely confirmed by the history of the Norwegian emigrants?

In the chapter on hereditary transmission and predisposition it was seen that the disease has a predilection for certain families. It was further shown that heredity cannot justly be considered the cause thereof. It may be asked, whether this fact be not explicable on the theory of the contagiousness of leprosy. From a casual inspection of Tables IX, X, Xa, and Xb of Chapter IV, it might appear as though this were really so. Further consideration will prove, that even assuming the spread of leprosy within a family to be due to contagion, yet the danger of a general increase of the disease throughout the country on this account is exceedingly slight. Firstly, amongst all the families of which one member at least was a leper, in only from 5 to 8 per cent. at the most can the disease be said to have spread within the family. Secondly, this diffusion within the family is very slight. For as Table II of this chapter shows, of 1,691 persons who came into close contact with lepers, only 95, or about 5 per cent., became affected.

Comparing Table I of Chapter IV with the present table, there seems at first sight to be a great discrepancy. From the former it might appear that in 264 out of 2,371 families, or in 11.1 per cent., the disease had attacked more than one member; that is, spread more or less within the family; while according to the latter only 95 out of 1,691 individuals living with a leper in a family became affected. The difference in the figures is due to the fact that in the enquiry into an hereditary taint, the evidence afforded by the patient's immediate ancestors naturally was fully considered, as well as that afforded by his own children, while for the construction of Table II of this chapter, only the latter and the history of husbands or wives were taken into account. If the tables had been constructed on equal lines, no doubt many more instances of

an assumed contagion might have been added. But, on the other hand, a far greater number of cases would have been found where such a possible infection could not be claimed. For there are many instances where a leper confessed to having lived with his parents and brothers and sisters without infecting them. Again, in a discussion of heredity it makes no difference whether the leprous ancestor was separated from his family or not. In Table I of Chapter IV, therefore, all the cases have been considered where the children had been removed from their parents, or developed the disease many years after their death. Finally, of the 264 lepers with an hereditary history, several were members of the same families, so that if the table is to be used as an argument for a spread by contagion within a family, evidently certain deductions will have to be made.

Making every allowance for these differences in the construction of the tables, it is evident that the discrepancy is only apparent.

Table I of Chapter IV, therefore, as it stands cannot be applied to prove or disprove contagion. It can only show, that taking all the families in which one individual at least is a leper, in considerably less than 11.1 per cent. another member of the same family becomes affected. To apply it to the subject under discussion, all instances in which contagion can be positively excluded must be omitted and each family taken as a whole. As the cases mentioned in Tables IX and X of the same chapter are comprised in Table I no further comment is necessary regarding them. The deductions from Table Xa are strong arguments in favour of the views expressed in this chapter, while the cases selected for the construction of Table Xb are too special to permit any general conclusions being drawn from them.

The discrepancies are, therefore, only on the surface. To study the possible influence of contagion within a family, all the members of such family must be considered—wives and

husbands as well as children—and it must be demanded that the individuals had actually exposed themselves to the risk of infection by intercourse with lepers, that is,—separation and segregation must be absolutely excluded. All these conditions have been fulfilled in Table II of this chapter.

TABLE III.

To show in how many Cases a Supposed Contagion can be traced from Husband to Wife, or vice versa.

NAME OF ASYLUM, ETC.	No. of couples of which one individual was affected with leprosy for at least five years.	No. of instances in which disease spread from one to the other.	REMARKS.
Agra	15	1 ⁽¹⁾	(1) Husband was a leper at time of marriage and died three years later. Fourteen years after his death the widow was attacked. Wife a leper sixteen years after death of husband.
Aligarh	4	...	
Almora	9	1	
Bangalore	10	2	
Benares	7	...	
Bombay	26	3 ⁽²⁾	(2) In one case the husband was a leper; twelve years after his death the widow was attacked by leprosy.
Burdwan	9	...	
Calcutta	24	...	
Calicut	11	...	
Cawnpore	4	...	
Conjeeveram	7	...	(3) Husband was a leper for four years and then died; two years later his widow was affected.
Darjeeling	1	...	
Dehra Dun	9	1 ⁽³⁾	
Delhi	5	...	
Fyzabad	6	...	
Gwalior	5	...	
Gya	8	1	
Hyderabad	6	...	
Jubbulpore	5	...	
Lucknow	2	...	

Table III—continued.

To show in how many Cases a Supposed Contagion can be traced from Husband to Wife, or vice versa.

NAME OF ASYLUM, ETC.	No. of couples of which one individual was affected with leprosy for at least five years.	No. of instances in which disease spread from one to the other.	REMARKS.
Madras	25	1	(4) In two cases the diagnosis was very doubtful.
Madura	41	3 ⁽⁴⁾	
Mandalay	34	...	
Moulmein	2	...	
Nagpur	26	3 ⁽⁵⁾	(5) In one case husband and wife affected at the same time.
Naini and Allahabad	8	...	
Prome	11	...	
Purulia	13	4	
Rangoon	9	1	(6) In one case wife acquired leprosy three years after husband's death, who had had leprosy for six years.
Rawalpindi	1	...	
Sialkot	1	...	
Subathu	4	...	
Tanjore	3	...	
Tarn Taran	17	4 ⁽⁶⁾	
Thayetmyo	7	...	
Trichinopoly	5	...	
Umballa	1	...	
TOTAL	381	25	

It will be seen from this table that there were 381 couples of which one member became a leper and continued to live with the other for a certain period. Or, expressing it in other words, 381 healthy persons lived intimately with an equal number of individuals, exposing themselves to all possible risk of contagion, and of this number only 25 subsequently became

affected, or 6.5 per cent. Six of these cases may fairly be subtracted, so that of 381 people living with an equal number of lepers only 19, or 4.9 per cent., became diseased, accepting the doubtful cases, two in number, as trustworthy.

Only those cases have been chosen where couples had been married for at least five years, the average time being from seven to ten years. There can be no doubt that an enquiry into the condition of people married to lepers is the best mode of ascertaining how far contagion influences the diffusion of the disease. As Drs. Lewis and Cunningham said in their report:¹⁸ "The means which most naturally suggests itself for enquiring into the theory that leprosy is a contagious disease is an examination of the history of all the married lepers, for were the result of this to show that the wives or husbands, as the case might be, of lepers suffer frequently from the disease this would be some evidence in favour of contagion." From the above table it will be seen, that even allowing a long incubation period, the ratio of people affected is too small to warrant a belief in contagion as a factor of much importance. If it be remembered that the married people lived in endemic areas, the possibility of a *de novo* development of the disease must undoubtedly exist.

In Table II the evidence afforded by whole families is given, and it is at once seen that these two tables correspond in every respect. However, do instances of a possible contagion exist amongst people who have been married to lepers for less than five years? There were only five such cases, two at Bombay, two at Madras, where each individual after having lived with a leper husband for three years developed the disease, and one at Tanjore. Here two people had been married for sixteen years, and then the husband became a leper and was left by his wife, who, within six months, was said likewise to have been attacked by the disease. The woman could not be examined,

(¹⁸) Op. cit., page 56.

and the diagnosis was highly questionable. But even allowing the latter to be correct, it would seem probable that this is not an instance of contagion, but that in these two people the disease was the effect of the same causes.

A table will now be added, giving the number of people who have been married to lepers, and who have lived with them for less than five years, for periods varying from six months to four years, three years being the average, since the manifestation of the disease, and stating in how many instances leprosy occurred.

TABLE IIIa.

To show in how many Instances Persons married to Lepers for a Period of less than Five Years subsequently became Lepers.

NAME OF ASYLUM, ETC.	No. of couples of which one individual was affected with leprosy for less than five years.	No. of instances of possible contagion.	REMARKS.
Agra	9	...	
Aligarh	1	...	
Almora	9	...	
Bangalore	4	...	
Benares	2	...	
Bombay	27	2 (¹)	(¹) In one case a woman married a leper. He died two years later and four years afterwards the widow became a leper.
Burdwan	3	...	
Calcutta	5	...	
Calicut	4	...	
Cawnpore	1	...	
Conjeeveram	2	...	
Dchra Dun	12	..	
Delhi	1	...	
Fyzabad	1	...	
Gwalior	1	...	
Gya	5	...	

Table IIIa—continued.

To show in how many Instances Persons married to Lepers for a Period of less than Five Years subsequently became Lepers.

NAME OF ASYLUM, ETC.	No. of couples of which one individual was affected with leprosy for less than five years.	No. of instances of possible contagion.	REMARKS.
Hyderabad	2	...	
Jubbulpore	1	...	
Lucknow	1	...	
Madras	24	2	
Madura	16	...	
Mandalay	22	...	
Moulmein	7	...	
Nagpur	22	...	
Purulia	5	...	
Rangoon	15	...	
Rawalpindi	1	...	
Tanjore	1	1 ⁽²⁾	⁽²⁾ Husband and wife acquired leprosy within six months of each other.
Tarn Taran	7	...	
Thayetmyo	9	...	
Trichinopoly	1	...	
Umballa	1	...	
TOTAL	222	5	

It follows from this table that there were 222 couples of which one individual became a leper and continued to live with the other for a period of less than five years, and of the latter only five became tainted, or 2.2 per cent. The Tanjore case can perhaps hardly be included, so that the ratio would be reduced to .9 per cent. It may be assumed that a certain number will at a future date become affected. But in any case the two Tables III and IIIa taken together are strong arguments against an amount of contagion worthy of serious

practical consideration, as they plainly show that husbands or wives of lepers do not frequently suffer from the disease. The fact that in Table III a greater percentage of husbands or wives became affected may be explained in other ways than by mere prolonged contact with lepers. For it must not be forgotten that in almost every instance, at the time of marriage both individuals were healthy, and that subsequently one of them became affected, that is, all these people must presumably have lived under conditions favourable to the appearance of the disease. The further facts that they all have lived in endemic districts, and that leprosy is a highly chronic disease, make it less surprising to find a higher ratio of lepers in Table III.

TABLE IV.

Enumeration of Cases where Persons resided with Lepers for Longer or Shorter Periods, coming in constant and close Contact with them, without being attacked by the Disease.

These may be classified as—

- (1) Hospital or asylum officials.
- (2) Persons detained in asylums for some time on account of mistaken diagnosis, or voluntary inmates.

TABLE IVa.

Evidence afforded by Asylum Officials.

NAME OF ASYLUM.	Capacity of Official.	Term of Office.	Condition.	REMARKS.
Agra. —5 Officials.	(1) Hospital Assistant	14 years	Healthy	Does not live at asylum but visits it twice or thrice a day. Did not live at asylum, but cooked there all day.
	(2) Cook	30 "	died	
	(3) Water-carrier	15 "	Healthy	Lives at asylum with wife and family. These men had to rub lepers with gurgun oil, and did so for one year. They left two years ago, and are quite healthy.
	(4) Sweeper	15 "	"	
	(5) Six Dressers	1 year	"	

Table IVa—continued.

Evidence afforded by Asylum Officials.

NAME OF ASYLUM.	Capacity of Official.	Term of office.	Condition.	REMARKS.
<i>Almora.</i> =3 Officials.	(1) Resident Superintendent (2) Asylum Assistant (3) Asylum Assistant	20 years 25 " 17 "	Healthy " "	Aged forty-two years, is married and has had eight children, varying in age from eighteen to one and a half year. Whole family live in asylum compound, and are healthy.
<i>Calcutta.</i> =10 Officials.	(1) Washerman (2) " (3) Porter (4) Dresser (5) " (6) " (7) Sweeper (8) " (9) " (10) Water-carrier	20 years 14 " 7 " 15 " 9 " 1 1/2 " 7 " 4 " 4 " 17 "	Healthy " " " " " " " " "	Have to wash clothes of the inmates of the asylum. All the servants at the asylum have to change their clothes once a day, and the dressers twice. All have to take a daily bath.
<i>Calicut.</i> =3 Officials.	(1) Cook (2) Ward-cooly (3) Sweeper	30 years 12 " 23 "	Healthy " Leper for two years	His cousin is also a leper.
<i>Dehra Dun</i> =5 Officials.	(1) Keeper (2) Sweeper (3) " (4) " (5) Gardener	12 years " " " 6 years	Healthy " " " "	All live on the premises of the asylum.
<i>Dharmala</i> =4 Officials.	(1) Compounder (2) Gardener (3) Keeper (4) Sweeper	13 years 1 year 3 years 1 year	Healthy " " "	Lives on the premises in a detached bungalow with wife and family. All healthy. Cf. note about gardeners under Tam Taran.

Table IVa—continued.

Evidence afforded by Asylum Officials.

NAME OF ASYLUM.	Capacity of official.	Term of office.	Condition.	REMARKS.
<i>Madras</i> =9 Officials.	(1) Dresser (2) " (3) " (4) " (5) " (6) " (7) Tailor (8) Washerman (9) Cook	13 years 12 " 10 " 9 " 3 " 3 " 12 " 8 " 15 "	Healthy " " " " " " " Leper	Has to mend the clothes of the lepers (over 200 in number). Has to wash the clothes of the lepers. Was treated for leprosy before he joined the asylum (cf. Table 1).
<i>Naini</i> =1 Official.	(1) Attendant	Many years.	Healthy	Lives at the colony.
<i>Rawalpindi</i> =3 Officials.	(1) Dresser (2) Messenger (3) Cook	25 years 13 1/2 " 25 "	Healthy Doubtful Healthy	Fingers and face look a little suspicious, but there is no anaesthesia. His mother was a leper in the asylum. He was brought up there, and afterwards engaged as cook.
<i>Sialkot</i> =5 Officials.	(1) Compounder (2) Water-carrier (3) Sweeper (4) Washerman (5) Gardener	22 years 12 " 2 " 2 " 2 "	Healthy " " " "	The former water-carrier left after being at asylum fourteen years. He is still alive and healthy.
<i>Subathu</i> =5 Officials.	(1) Messenger (2) Carpenter (3) Compounder (4) " (5) Missionary	12 years 15 " 8 " 3 " 4 "	Healthy " " " "	All these officials live on the premises.

Table IVa—continued.

Evidence afforded by Asylum Officials—continued.

NAME OF ASYLUM.	Capacity of Official.	Term of office.	Condition.	REMARKS.
Tarn Taran = 11 Officials.	(1) Keeper	3 years	Healthy	Lives at asylum with his wife and family. They, like all the servants, live on the premises. They use the excreta of the lepers for gardening purposes. Their families also reside here.
	(2) Gardener	13 "	"	
	(3) "	6 "	"	
	(4) Water-carrier	4 "	"	
	(5) "	1 "	"	They clean out the tanks where the lepers bathe, and while doing so are in the habit of having a bath themselves.
	(6) "	1 "	"	
	(7) Sweeper	7 "	"	
	(8) "	6 "	"	
	(9) "	5 "	"	
	(10) "	1 "	"	
	(11) Compounder.	2 "	"	

From this table it will be seen that of sixty-nine asylum officials only three were affected with leprosy. Of these one had the disease before he entered the service (Madras), and a second case is doubtful (Rawalpindi); so that actually only one out of sixty-nine had become tainted, or 1.5 per cent. Including the doubtful case a possible contagion can be traced in only 3 per cent., a fact which, even on the assumption that some of the attendants may subsequently develop leprosy, nevertheless gives little support to the view that leprosy is spread by contagion.

TABLE IVb.

Enumeration of Instances where Persons other than Officials resided in the Asylums with Lepers.

(1) *Almora*.—In the asylum there were eleven people, blind, lame, and imbecile. Of these, two inmates, aged forty and forty-five years, respectively, had been there for twenty-eight years. Two, aged sixty and forty, had lived there for eight years, and another, aged forty, for seventeen years. The other

six had resided at the asylum severally for eleven, five, three, three, two, and one year. All these were examined by the Commissioners and found to be free from leprosy.

(2) *Calcutta*.—Here there were two cases.

(a) A Native Christian, seventy years old, who has been in the asylum twenty-five years, lives in a ward with lepers. He eats and drinks with them and often consumes what they have left, or what they give him. He drinks out of the same vessels and smokes the same hookah. He was found to be suffering from multiple molluscum fibrosum, but otherwise quite healthy. He will not leave the asylum, as he finds it comfortable.

(b) A woman, who suffers from hysteria and eczema, has been in the asylum for twelve to thirteen years in close contact with four leper inmates. She is quite free from leprosy.

(3) *Lucknow*.—(a) A man and his mistress were admitted on July 7th, 1876. He was a leper, she was healthy and lived in the poor-house with him and the other inmates until June 9th, 1881, when he died. Their child is now twelve years old. He and his mother remained in the poor-house with the lepers, so that she has been there fifteen years and—

(b) her boy, twelve years. Both are quite healthy.

(c) A woman was admitted July 5th, 1878, under the supposition that she suffered from leprosy. She married a leper in the poor-house, but had no issue. A son of a former marriage, sixteen years of age, came to Lucknow and has remained there with her, so that she and—

(d) her son have lived amongst lepers for thirteen years without becoming tainted by the disease.

(4) *Madras*.—A boy, an Eurasian, seventeen years of age, had been in the leper asylum for two years. He was admitted on account of a wrong diagnosis and was very reluctant to leave. He was quite healthy.

(5) *Subathu*.—(a) A man, who up to the present time is free from the disease, has lived at the asylum for seven years, sharing a room with a leper, and eating and drinking with him.

(b) A woman, whose husband was a leper and died at Subathu, has lived there for eight to nine years. She is quite healthy and has remained at the asylum to help the female lepers.

(c) Another woman was admitted from motives of charity, and has lived amongst the lepers for ten years, being at present free from the disease.

(d) A third woman has voluntarily lived among the lepers for three to four years, and has remained healthy.

(6) *Tarn Taran*.—(a) A woman married a leper at the asylum and lived there for ten years. They had two children. She and—

(b and c) her two children are healthy.

(d) A drover's wife, after her husband's death, had frequent intercourse with the lepers of the asylum for the last twelve years, giving birth to three children. At present all these are over eight years of age. She and—

(e, f and g) her children, have resided there and are absolutely healthy.

(h and j) Two children were seen, ten and twelve years of age, respec-

tively, who were born at the asylum of leper parents, and being orphans, have been maintained there. They showed no signs of the disease.

(k) A woman, twenty-five years of age, was examined. Both her parents were leper inmates of the asylum when she was born. Her father died when she was two years old, and her mother when she was twelve years of age. She was then taken care of by a female leper in the asylum and has married a leper there. She has three children now, all over four years of age. She and—

(l, m and n) her children are perfectly healthy.

These cases will now be given in a tabular form.

NAME OF ASYLUM.	Condition on Admission.	Present Age.	Term of residence at the Asylum.	Present Condition.
<i>Almora</i> = 11 Cases	All these eleven people were either blind, lame, or imbecile.	40 years 45 " 40 " 60 " 65 " 40 " 30 " 55 " 20 " 20 " 20 "	28 years 28 " 17 " 11 " 8 " 8 " 5 " 3 " 3 " 2 " 1 "	Healthy. " " " " " " " " " "
<i>Calcutta</i> = 2 Cases	(1) Molluscum fibrosum . (2) Hysteria .	70 years About 50 yrs.	25 years 12-13 "	Healthy. "
<i>Lucknow</i> = 4 Cases	(1) Healthy woman . (2) Son of (1) . (3) Healthy woman . (4) Son of (3) .	About 30 yrs. 12 years About 30 yrs. 16 years	15 years 12 " 13 " 13 "	Healthy. " " "
<i>Madras</i> = 1 Case	Eurasian boy, free from leprosy.	17 years	2 years	Healthy.
<i>Subathu</i> = 4 Cases	(1) Healthy man . (2) " women . (3) " " . (4) " " .	Adult . " . " . " .	4 years 8-9 " 10 " 3-4 "	Healthy. " " "

NAME OF ASYLUM.	Condition on Admission.	Present Age.	Term of residence at the Asylum.	Present Condition.
<i>Tarn Taran</i> = 13 Cases	(1) Healthy woman . (2) } Her two children (3) } (4) Healthy woman . (5) } Her three children (4). (6) } (7) } (8) Healthy child . (9) " " . (10) Healthy woman . (11) } Her three children. (12) } (13) }	Adult . Under 10 . " . About 40 yrs. All over 8 years. " . 12 years . 10 " . 25 " . All over 4 years. " . " .	10 years . Since birth . " . 12 years . Since birth . " . 12 years . 10 " . 25 " . Since birth . " . " .	Healthy. " " " " " " " " " " "

In this table are thirty-five cases, all well authenticated and personally examined by the Commission, where people were exposed to the dangers of contagion, and yet escaped the disease. Adding these thirty-five cases to the previous sixty-nine cases of Table IVa, it will be seen that of one hundred and four persons, living under conditions highly favourable for contracting a communicable disease, only one, or possibly two, have become lepers; that is, 1 or 2 per cent.

TABLE V.

Evidence in Favour of Contagion afforded by Persons Eating and Drinking with Lepers.

ASYLUM OR CENTRE.	No. of Lepers.	No. of persons eating and drinking with them.	How many of these are affected.	REMARKS.
Agra . .	5	11	3	In one case two brothers used to eat and drink together; one of them became a leper; and fifteen years later, the other. In another case a leper father and his two daughters used to eat together. He died, and some years later the two daughters became diseased at the same time.

Table V—continued.

Evidence in Favour of Contagion afforded by Persons Eating and Drinking with Lepers.

ASYLUM OR CENTRE.	No. of Lepers.	No. of persons eating and drinking with them.	How many of these are affected.	REMARKS.
Aligarh .	1	1	1	Child used to eat with a leper father, and eight years after his death also became tainted.
Benares .	4	4	1	Child used to eat with leper mother, and five years after her death became also a leper.
Calcutta .	19	43	3	In one instance two brothers used to eat together, and within a year both were lepers. In another, a child had eaten with its leper father, and was twelve years old when the latter died. Sixteen years after his death the child became a leper.
Delhi .	2	5		
Gwalior .		1		
Gya .	7	7	...	The wives were accustomed to eat with their leper husbands, but it was distinctly stated that they washed the plates after the husbands had used them, and before they employed these for their own meal.
Mandalay .	24	84	5	In one case a child used to eat from the same vessels as her mother, and thirteen years after the latter's death she also became affected.
Prome .	13	40	3	In one instance a family of nine used to eat from the same dishes. One of them became a leper and died a year later. They continued after this to eat from the same vessels, and two years later another member of the family was attacked. The others remained healthy.

Table V—continued.

Evidence in Favour of Contagion afforded by Persons Eating and Drinking with Lepers.

ASYLUM OR CENTRE.	No. of Lepers.	No. of persons eating and drinking with them.	How many of these are affected.	REMARKS.
Thayetmyo .	10	16	5	In one case the disease appeared in two people at the same time, and, therefore, one cannot be said to have infected the other. In another case the diagnosis of leprosy in the supposed infected person was extremely doubtful, and in a third instance two persons eating together developed the disease within a year of each other.
TOTAL .	86	212	21	

For the construction of this table, only the information obtained from asylums and districts in which the Commissioners paid special attention to this point, has been considered. In all the cases, with the exception of those in Gya, families used to eat at the same time, and out of the same vessels. Since at Gya the wives previously washed the dishes from which their leper husbands had eaten, these seven cases must be excluded in calculating the possible influence of contagion. Hence the figures show that of two hundred and five persons who exposed themselves by eating and drinking with lepers to the danger of infection, only twenty-one became affected. Moreover, in the one instance where two individuals who had constantly eaten together from the same vessels became diseased at the same time, there can be no question of contagion. Again, cases of persons who had not come into contact with lepers for a long period cannot be quoted in favour of contagion. Five such instances are to be found in Table V, one from Agra, one from Aligarh, one from Benares, one from Calcutta, and one from Mandalay. The assumption of so long an incubation period as

five years or more means practically reducing the influence of contagion to an absurdity. Six cases, therefore, must be subtracted from the twenty-one instances of possible contagion through eating and drinking with lepers. Besides, in one case (Thayetmyo), the diagnosis was extremely doubtful, and in two cases (Calcutta and Thayetmyo), the disease may be said to have commenced in the two persons at the same time, as they were affected within a year of each other. It is also very questionable whether one of the cases recorded from Prome can be cited with all fairness as an example of possible contagion from these causes. Allowing, however, that these cases are free from objection, the figures show that of two hundred and five persons who exposed themselves to the risk of contagion by eating and drinking with lepers, fifteen might be claimed as exemplifying an assumed influence of contagion, or 7.3 per cent. These figures cannot be said to favour the hypothesis of an infection through eating and drinking with lepers, especially when it is remembered that 7.3 per cent. is probably considerably above the actual ratio, which perhaps is more nearly represented by 5 per cent., even assuming that the spread of the disease among these people depends on contagion only.

TABLE VI.

Observations on Lepers vaccinated at the Almora Asylum.

Eighty-six persons were vaccinated, and of these 40 successfully.

Of the 40 successful cases, 34 were anæsthetic lepers.

5 were mixed cases.

1 was tubercular.

Observations on Lepers vaccinated at the Almora Asylum.

In 31 patients the vesicle was normal.

2 " " " " purulent.

2 " " " " purulent and mixed with blood.

1 " " " " normal on one arm and purulent on the other.

In 31 patients the vesicle was normal but mixed with blood on puncturing it.

1 " " " " immature and mixed with blood on puncturing it.

1 " " " " immature.

1 " " " " immature and the crust removed for examination.

Ninety-three cover-glasses were prepared and stained for bacilli, and specimens were also taken later from the crusts of two vesicles which had been normal.

Condition of site of vaccination—In 14 patients the skin was normal.

" 12 " sensation was diminished.

" 13 " there was an anæsthetic patch.

" 1 patient the skin was tuberculated.

Results :—In no case were leprosy bacilli undoubtedly found.

In two specimens prepared from a vesicle over a tuberculated ear there were one or two badly stained bacilli.

In four specimens from an anæsthetic patch there were some rods which stained with fuchsin and looked suspicious, but none of these were certain.

TABLE VII.

I.—Observations on Earth at the Almora Leper Asylum.

SOURCE OF EARTH.	No. of cover-glasses examined.	Number of Leprosy Bacilli found.
1. Path in front of office	25	3 on 1 cover-glass.
		2 " 1 " "
		1 " 1 " "
2. Path down hill to leper quarters	25	1 " 1 " "
		1 " 1 " "
3. Path under bank where lepers sit	25	1 " 1 " "
4. Bank where lepers sit	25	No bacilli. [One suspicious.]
TOTAL	100	10 bacilli in 100 observations.

Table VII—continued.

II—Examination of Dust from Leper Huts.

SOURCE OF DUST.	No. of cover-plates examined.	RESULT.
1. Room inhabited by tubercular leper with ulcers on both feet	100	Negative.
2. Ditto ditto	100	"
3. Ditto with ulcer on right foot	100	"
4. } Three rooms inhabited by anaesthetic	50	"
5. } lepers with extensive ulcerations.	50	
6. }	50	

CHAPTER VI.

Sanitation, Diet, and Diseases in relation to Leprosy.

Sanitation.

IT has been seen that heredity and contagion are altogether insufficient to explain the spread of leprosy, and other ætiological factors must be sought for. In diseases like leprosy and tuberculosis, it is always difficult to find the exciting cause. For, with the recognition that a specific bacillus enters the body, the matter is but little advanced. The enquirer must always ask, why a widely diffused microbe, such as that of tuberculosis or leprosy, should cause a particular disease in some people and not in others. What is it that establishes the necessary specific predisposition?

This question is as obscure for leprosy as it is for tuberculosis. In this chapter the more important causes, supposed to bring about such specific predisposition, will be discussed.

When a disease, as is the case with leprosy, is so generally distributed over a vast country, attention must be directed to the general life and hygienic surroundings of the people. Does defective sanitation cause a specific predisposition to leprosy?

Since all classes of the community and all races appear to be subject to leprosy, remarks upon the sanitary environment of the inhabitants of India must be necessarily general in character. In the cities and larger centres of population considerable progress has of late years been made in sanitary improvement, though very much yet remains to be done. In the smaller towns and villages, however, little has been accomplished, or, indeed, is practicable in the present state of native opinion. Fortunately the nature of the employment of the great mass of the population necessitates an outdoor

life, and the free air-flushing of the village site, and the rapid desiccation of the objectionable matters thrown upon it, go far to reduce the consequences of habitual neglect of sanitary principles.

These matters will now be dealt with in detail. As regards conservancy, it is found that the cities and larger towns are provided with suitable latrines, which are in charge of an adequate conservancy staff, and which are largely used by the people. The excreta from these latrines, and also the general refuse and rubbish of the town, are regularly removed to a distance, and there buried, burnt, or otherwise suitably disposed of. Although differences exist in various localities as regards the efficiency of these arrangements, they may be described as upon the whole fairly good. But no large centre of population is free from many nuisances. Ruined huts and waste pieces of land are frequently used for purposes of nature, cesspools exist in many courtyards and in immediate proximity to wells, excavations full of fetid water are frequently observed, and other sources of danger to the public health are only too common.

In the smaller towns and villages little or no attempt at organising conservancy arrangements is made. The villager deposits the refuse and sweepings of the dwelling in the immediate vicinity of the house or hut, in some cases from indifference, in others to avoid theft of such matters before their employment for agricultural operations. For purposes of nature he generally resorts to a field in the neighbourhood, or to the banks of a stream or pond. Refuse water is allowed usually to flow from his hut into the adjacent road. It should be noted, however, that despite the frequently objectionable nature of its surroundings, the interior of the average village dwelling is usually fairly clean.

Most cities and towns have a more or less satisfactory system of drainage as regards the main thoroughfares, but the climatic conditions of the country, and the fact that so many

months of the year are almost rainless, render the flushing of these water-ways a matter of extreme difficulty, and often an impossibility. Where the configuration of the land permits, attempts are often made to utilize streams and other sources of water for the purpose, but a glance at a physical map of India will show how in the extensive flat plains of the country no such procedure is possible. Again, although much has been, and is being, done to ensure efficient drainage of inhabited sites, such efforts have up to the present time been more especially directed to the carrying off of water from the thoroughfares and streets. Small drains, it is true, connect the dwellings with the larger channels, but inasmuch as the inhabitants bathe at the public wells and tanks, and practically only employ such water in their houses as is required for drinking and cooking, little or no flow in these connecting drains is usually observable. Few towns as yet in India possess a water-supply laid on in pipes to the houses.

In the villages and smaller centres of population water finds its way more or less completely from the site through small cuttings in the soil, or through a channel created naturally by the heavy rainfall during the monsoon.

As regards water-supply, some of the larger towns and cities, as Calcutta, Bombay, Madras, Agra, and certain others, are provided with a good supply laid on in pipes. But the great majority of places have no such arrangements, and here the water is taken from wells, rivers, springs, tanks, or lakes. From both wells and rivers the water is usually more or less impure, though superior to that from lakes and tanks. Spring water when obtainable is, as might be expected, usually good. Attempts to sink Artesian wells have succeeded in a few localities, but have more generally failed. Local authorities in the larger centres have of late years succeeded in improving the supply by such measures as keeping in repair the wells that hold good water and closing those of which the contents are impure, by remodelling tanks and preventing their pollution,

but in the villages little at present can be done in this direction.

Habitations necessarily vary in size with the wealth and position of the owner or tenant. They are more generally built of bricks and mud in the plains, of stone in the hill tracts, and of bamboo and wood in Burma and certain parts of India. In towns and cities they are usually placed in close proximity to one another, and thereby efficient ventilation and air-flushing of the site are interfered with. Overcrowding of these dwellings is the rule, and in the hill tracts is often excessive. The residents, however, live largely in the open air, and doors and windows are either seldom closed, or are so carelessly constructed that air freely enters the house or hut.

In connection with habitations, it should be mentioned that not only in India but also in other parts of the world the mosquito has been much feared. As Dr. Arning says:¹ "Ashmead seems to fear much the bite of the mosquito, and I quite agree with him that the idea of transmission of leprosy through the sting of an insect is a very plausible one." Dr. Arning himself "frequently examined mosquitoes bacterioscopically, which were found inside the mosquito nets of beds containing cases of severe cutaneous leprosy. He caught the insects when they were quite full of the blood sucked from the patients. He never discovered any trace of leprosy bacilli, either in or upon them." Some members of the Commission examined flies and mosquitoes, but also with negative result, as will be seen from the Laboratory Report. Other considerations, however, make it appear extremely unlikely that a propagation of the disease should be due to these insects. It is hardly possible that the toxic principle of the mosquito should contain bacilli, even though they be present in the blood with which the insect is gorged. Again, cases of transmission from patients to hospital or asylum officials should be very common

(¹) Journal of the Leprosy Investigation Committee, No 2, February 1891, page 132.

if this theory be true. Yet in Calcutta, where mosquitoes and flies abound, no instance of a transmission of the disease from a leper to a healthy individual has ever occurred at the asylum. All over the plains these insects are common, and nevertheless, with the exception of a single case in Calicut, no instance of infection could be found, even amongst the people who voluntarily resided with the lepers in the asylums. In fact it may be said that the whole chapter on contagion lends no support to the insect theory.

Personal cleanliness in India is very much a matter of climate. Where this is warm or mild all classes bathe frequently, Hindus more especially. In such localities linen and cotton clothes are worn and are regularly washed. But in colder latitudes far less attention is paid to regular ablutions, and where the climate demands the use of woollen clothing, such garments are seldom washed and become extremely foul. In the hill tracts the people may be said to rarely bathe, and are, as a rule, extremely dirty in their persons and habits. Most people possess shoes, but they are as often as not discarded, the owner walking for preference barefoot.

Scabies is very common all over India, and it has been asked whether or no this may contribute to the spread of the disease. This assumption may be refuted by the arguments used against the theory of propagation by insects, and it will not be necessary to enter into this question any further. It may be mentioned, however, that itch pustules were examined for the bacillus in several instances, but always with negative result.

It is quite impossible to assume that defective hygiene, whether general or personal, alone would originate leprosy. For, as will be seen from the above short review, the hygienic conditions vary considerably even in leprosy areas, and the disease capriciously spares certain portions of a country where the condition of the population is identical with that of those attacked. In India the disease is found in the richest and

poorest provinces. Defective hygiene, exposure to hardships and privations, filthy dwellings and want of personal cleanliness cannot be said to predispose to leprosy more than to any other disease of like nature. They necessarily must aggravate and accelerate it, when it is once established; and for this reason, where they exist, require improvement.²

Diet.

The next question to be considered is the important one of diet. Since the earliest days in the history of leprosy the greatest influence in the ætiology of the disease has been attributed to defective or bad dietetic conditions. In turn almost every foodstuff has been accused. In ancient medical history the eating of certain kinds of fish, fresh or decayed, was considered of great importance, and this opinion has persisted to the present day. Too much or too little animal or vegetable food has also been held responsible for the origin of the disease, or specific predisposition to the same. This influence of diet was naturally as keenly disputed by others.

That food should have a specific effect in the ætiology of a chronic disease is *à priori* quite within the bounds of possibility. No one who believes in the infective nature of leprosy would of course assume food to be a final exciting cause, for it is implied in the term "infective disease" that this must be a parasitic organism. It must be remembered, however, that when these various food-theories were propounded, the bacillus had not been discovered, and that, therefore, the views of many of the older authors would not be misrepresented, by stating that they claimed for diet only a direct effect in the establishment of a specific predisposition.

Certain forms of diet are capable of producing grave morbid conditions, as, *e.g.*, *Lathyrus sativus* and *Ergot*; others, on the other hand, cause more general changes in the

(²) Cf. R. Liveing: *op. cit.*, pages 76 and 77.

body, and may thus possibly lead to those conditions which establish a specific predisposition.³ In fact the experiments of H. Leo⁴ lend much support to such a theory. "He administered phloridzin in small doses along with food to white mice for some days previous to inoculation, with the result that sugar became present in the tissues of the experimental animal. He found that the animals which are normally but little susceptible to glanders infection became highly susceptible to it, if previously dosed with phloridzin." In connection with this subject, it may also be mentioned, that Charrin and Roger⁵ have shown "that ordinary normal rats, which, as is well known, are very little susceptible to anthrax, become susceptible to this disease in a marked degree if they are, when caged, made to work a treadmill so as to become thoroughly fatigued."

Food must necessarily modify the constitution of the tissues and may do so in such a way as to prepare them to respond at once to the introduction of microbes against which they would otherwise have proved refractory or insusceptible. Thus Monti⁶ has shown that by a separate injection of a sufficient quantity of the chemical products of the *Proteus vulgaris* into rabbits, mice or other rodents, these animals could easily be made to succumb to an infection with cultures of the *Diplococcus pneumoniae*, which through repeated subculture or age had lost their virulence, and which without the chemical products of the saprophyte were also entirely harmless. As Dr. E. Klein,⁷ who confirmed and extended Monti's experiments, says, "insusceptibility of the tissues is, as is well known,

(³) R. Liveing: *op. cit.*, page 83.

(⁴) H. Leo: *Zeitschrift für Hygiene* VII., 3; and Nineteenth Annual Report of the Local Government Board; Supplement, 1889, page 217.

(⁵) Charrin and Roger: *La Semaine Médicale*, 1890, 4; and Nineteenth Annual Report, etc., *loc. cit.*

(⁶) Nineteenth Annual Report, etc., *loc. cit.*

(⁷) E. Klein: Nineteenth Annual Report of the Local Government Board Supplement 1889, page 217.

considered by some authorities to be connected with, if not wholly dependent on, the chemical nature of the tissues; so that while the tissues are normal or in full vigour (if the phrase may be allowed for the purpose of illustrating my meaning), a particular microbe getting access to them fails to thrive—cannot, so to speak, overcome the resistance or inimical action offered by the tissues. This power of resistance of tissues can, however, be greatly reduced or even abolished by certain means, such as depression of their vitality either due to ptomaines and certain other chemical substances which have invaded them, or to nervous exhaustion, and the like."

Where food is considered of ætiological importance in the production of an infective disease, there are, broadly speaking, two ways in which it may cause the latter. "First, by a direct introduction of the bacillus into the alimentary tract; secondly, by causing changes in the tissues capable of rousing into activity a bacillus already existing in them,"⁸ or of offering a suitable soil to a bacillus subsequently introduced into them.

These points will be kept in view in the following discussion. At the present moment three substances have been specially singled out as having a causal relation to leprosy, *viz.*, fish, salt, and water. However, before discussing the effect of food in general, and of these three articles in particular, a few remarks on the diets of the Indian community must be made.

The inhabitants of India are almost entirely vegetarians, and the majority of people do not touch flesh from one year's end to another. Muhammadans, it is true, make flesh, other than that of the pig, a regular article of diet, but expense usually prevents its extensive consumption, and it is used generally in small quantities to supplement the main vegetable elements of their food. Hindus are vegetarians, but certain

⁽⁸⁾ Journal of the Leprosy Investigation Committee, No. 1, August 1890, page 77.

of the lower classes will readily eat meat, and Chamars will even consume the flesh of animals which have died of disease. Rajputs, especially in Central India, and wild forest tribes, eat what flesh may be killed in the chase, though some of pure Hindu blood refuse that of deer and pigs. Fowls and eggs are readily eaten in some parts of the country, but are regarded with abhorrence in others. Milk, curds, "ghee," or clarified butter are universally consumed.

As above stated, the great majority of inhabitants are vegetarians and live upon the crops raised in the country, the coarser grains being used by the poorer, and the finer by the richer, classes of the community. The subjoined table and remarks taken from the Report of the Famine Commission in 1880 will show the distribution and consumption of the various staples.

PROVINCE.	PERCENTAGE OF FOOD-GROWING AREA UNDER		
	Wheat or Barley	Millets.	Rice.
Punjab	54	41	5
North-Western Provinces	57	34	9
Bengal, Assam, and Burma	Not known (but principally rice).		
Central Provinces	27	39	34
Berar	17	82	1
Bombay	7	83	10
Madras	—	67	33
Mysore	—	84	16

"In the Punjab, North-West Provinces and Oudh, in Behar, in the northern part of the Central Provinces, and in Gujarat, the poorer classes live on the millets grown in the rains and on barley and gram; the richer classes eat principally wheat and rice. In Bengal proper and Orissa, and the eastern portion of Central India (and in Burma) rice is the principal food, the coarse early rice being mainly taken by the poor, the

finer late rice by the rich. In the South, or Mahratta-speaking part of the Central Provinces, in Berar, in Bombay, the Deccan, and the northern part of Madras, the two large millets—jowar and bajra—form the principal food, the Brahmins usually living on imported rice and wheat. In Mysore the ordinary food is the small millet (ragi). In the southern part of Madras and the western districts of Bombay rice is chiefly consumed, though there is a good deal of millet grown and eaten." All classes mix pulses with their food in order to obtain the necessary nitrogenous elements. Maize, though grown more or less everywhere, is not so largely consumed as might have been expected. Vegetables, such as spinach, pumpkins, carrots, potatoes, and useful wild herbs are largely used, and condiments, such as chillies, are taken with the meal to assist digestion. Fruit, such as that of the nihowa, mango, plantain, and cocoanut are eaten when obtainable, and oil and salt form part of every dietary.

* Both sea and fresh-water fish are largely consumed wherever they can be caught. Dried fish is used all round the coast, especially in the Madras Presidency and Burma. In the latter country "nga-pi" or dried fish, more or less in a state of decomposition, is almost universally eaten, but in small quantities and more as a condiment than as a food.

It would be a mistake to suppose that the consumption of fish in India is in any degree confined to the coast or the vicinity of large rivers. Nearly every tank, pond, lake, or rivulet holds species which are caught and eaten. In many parts of India this forms a portion of the dietary of even the higher castes.

Food in India is usually eaten out of metal or earthen vessels, or platters made of dried leaves, the consumer sitting on the ground, or upon a mat, and using the fingers in place of knives and forks. Among Hindus it is customary for the males to eat before the females. Flesh is roasted, stewed, or boiled, pulses are usually boiled, and grain is either parched, or far

more frequently ground, and the flour made into unleavened cakes known as "chupatties." Rice is boiled and either eaten alone or in the form of curries. As already stated, cooked vegetables, salt, oil, and condiments form portions of almost every dietary. Sugar, sweetmeats and fruits are also largely consumed.

Of all articles of diet none has been held more responsible for the causation of leprosy than fish. This view has of late years gained considerable importance through the weight of the authority of Mr. Jonathan Hutchinson who stated the fish hypothesis with great force at the Tenth International Medical Congress at Berlin.⁹ As Virchow and Dr. Liveing have pointed out, the theory is very old and has reappeared from time to time. Virchow's views on the subject have not infrequently been misrepresented, and it may, therefore, not be out of place here to quote his own words: "The more general use of bad fish very (ungewöhnlich) frequently coincides with endemic leprosy. This statement, however, is subject to exceptions, but then, as a rule, another noxious dietetic article is accused, and comparative observations might be made as to whether or no the same deleterious substance exists in fish and these other articles of food." It will not be necessary to say more about the history of the fish hypothesis, as this has been done so concisely by Dr. Liveing in his Goulstonian lectures. One passage, however, of special interest with regard to leprosy in India is worthy of notice. Dr. Liveing says: "The combination, however, of milk and fish seems to have been considered especially favourable to the disease. Bernhard Gordon says: 'Comedere lac et pisces in eadem mensa inducit Leporam.' And it is not a little remarkable that the same opinion obtains in the present day in India." There is no doubt that in certain

(⁹) Journal of the Leprosy Investigation Committee, No. 1, August 1890, pages 77-87.

(¹⁰) R. Virchow: op. cit., page 507.

(¹¹) R. Liveing: op. cit., page 33 and footnote, page 34.

parts of the empire this opinion is very prevalent, especially in Kashmir and the hill districts. Lepers in India also frequently assert that after a fish meal their state is exacerbated.

Coming now to the discussion of the fish hypothesis and its application to Indian leprosy, it will be best to take it in its two chief parts. Mr. Jonathan Hutchinson says⁽¹²⁾: "It is possible that fish may cause the disease in one of several ways. First, it may be by the direct introduction of the bacillus into the stomach; secondly, it may be that some element in fish-food rouses into activity a bacillus already existing in the tissues."

Taking the first point, it should be possible to find the bacillus not infrequently in fish caught in endemic areas. *A priori*, judging from the similarity between leprosy and tuberculosis, it would not seem impossible that the *Bacillus lepræ* is capable of growing in a cold-blooded animal. The Commission paid special attention to this point, and some members examined a large number of fish, fresh and dried, or prepared as "nga-pi," but with absolutely negative result. Dr. Arning, who has studied this part of the question most carefully, has also never been able to find any leprosy bacilli in fish. The value of such investigations is necessarily that of negative evidence, but until positive cases have been shown, is worthy of all consideration.

The fish hypothesis premises that all lepers at one time or another have eaten fish in some form. Perhaps India is the most suitable country to investigate this matter, for here people of all castes and religions are thrown together. There is no reasonable doubt whatever that the majority of Brahmins never touch flesh or fish, and the same applies to many of the Baniyas or traders in certain districts, and almost without exception to the Jains. There are many Brahmins, however, settled on the shores of the Bay of Bengal, who habitually eat fish, and it is

(12) Loc. cit.

not at all rare to find Brahmins in hill districts and also in the plains who do not refuse fish. But in the plains they are much stricter in this respect. Jains, however, under no circumstances touch any animal food. They are, in fact, so particular, that it is a custom amongst many of them to fasten a piece of cloth to the upper lip to avoid inhaling small insects. They will not eat or drink in the dark, and always strain water through a cloth before drinking. Their priests have a broom with which they sweep the road before them to avoid the supposed guilt of killing insects by treading them under foot. This is a regular custom among the Bhabras in the Hoshiarpur District.⁽¹³⁾ Now leprosy occurs amongst all these classes, and it seems indeed that the disease is impartially distributed among the fish-eating and non-fish-eating communities. It is only possible to talk of strong impressions, as accurate statistics and relative numbers cannot be drawn up, partly on account of the uncertainty of the present state of many castes and the changes which intercourse with Europeans has brought about. For instance, "among the lower ranks of Brahmins, great latitude is taken in regard to labour, food, etc., and their claim to the distinction of that caste is, in consequence, little recognised."⁽¹⁴⁾ On the other hand, the conditions in which the better castes live are so different from those of the lower, which undoubtedly supply, not only absolutely, but also relatively, the greater number of lepers, that comparisons would be unfair. The Baniyas or traders, of whatever caste or religion, for instance, are, generally speaking, a wealthy class, and the disease is acknowledged to be less common among prosperous people, though it does not spare them altogether. Now among the mixed class of Baniyas are many castes, the laws of which forbid the consumption of meat in any form. Many of the Baniyas in certain parts of India are attached to the Jain religion. In fact, it is a singular

(13) Gazetteer of the Hoshiarpur District, 1883-84, page 46.

(14) Lewis and Cunningham; op. cit., page 61, footnote.

circumstance that many of them are devoted to this or some other modification of the Buddhist faith. When, therefore, a Bania or Brahmin leper denies ever having eaten fish, it is at least possible from what is known of the habits and customs of these communities. This is especially true of Agra and the North-West Provinces, so far as the Banias are concerned.¹⁵ The Jains form one of the richest communities in India, yet the disease, though rarely, is found amongst them. Thus, at Hoshiarpur two of the Commissioners gathered, through the kindness of the Civil Surgeon Dr. Datta, reliable information concerning a leper from the Bhabra class, in whose case the cause of the disease could certainly not be ascribed to fish-eating.

It is not claimed that the fact of a man calling himself a Brahmin or a Bania is identical with saying that he has never eaten fish. It has already been said that many of the former consume animal food, and the latter include amongst their numbers many castes whose laws do not prohibit such a diet. This short exposition is meant to show that many of these people do never touch fish, and that, therefore, if a leper belonging to either class denies ever having done so, there is a fair probability of his statement being true.

Now Mr. Jonathan Hutchinson¹⁶ objects and says: "In recording the denial on the part of leprosy patients that they have been fish consumers, caution must be exercised. Those who belong to castes which are forbidden to eat animal food will naturally be prone to deny that they have deviated from the rule. The temptation to eat fish as a condiment must, in the case of those restricted to an exclusively vegetable diet, be very great. It is, under those circumstances, precisely those who eat it most seldom (dwellers far inland, for instance) who are likely to receive it in its most dangerous state of decom-

(¹⁵) M. A. Sherring: Hindu Tribes and Castes, 1872, pages 285-299.

(¹⁶) Journal of the Leprosy Investigation Committee, No. 1, August 1890, page 79.

position. It must always be remembered that members of castes forbidden to take life often eagerly avail themselves of all opportunities as regards what has been found dead or killed by others. Thus the bare statement that leprosy prevails in classes who, from religious scruples, never eat animal food is usually of no real value. Careful and even sceptical inquiry must be made as to whether the individual lepers had really, in the case of preserved fish, invariably abstained."

There is of course much truth in these assertions of Mr. Hutchinson, and the above facts have only been mentioned to show that it is possible to find amongst lepers, individuals belonging to castes not allowed to touch animal food. Now Mr. Hutchinson is inclined to doubt the statement of lepers who profess to observe the rules which caste or religion enforce on them. Yet if a comparatively large number of lepers are found who state that they have never eaten fish, and these belong to castes or tribes of which it is known that their rules forbid the strict observer to touch meat or flesh in any form or shape, it seems improbable that all of them should have deceived the questioner or themselves. The Commission paid particular attention to this question, and found that one hundred and sixty-two individuals denied ever having touched fish (Table I). Many of these were allowed to partake of animal food, but denied ever having eaten fish, though in all cases leading questions were avoided as much as possible. To see in what percentage of cases an abstinence from this article of diet could be traced, every leper of a certain number of asylums was interrogated, with the result that out of 464 lepers 99, or 21.3 per cent., denied having ever partaken of fish.

TABLE I.

Number of Lepers who denied having ever eaten fish.

ASYLUM OR LOCALITY.	No. of persons who never ate fish.	REMARKS.
Agra	7	3 Brahmins; 4 Banias.
Aligarh	3	1 Brahmin; 1 Bania.
Almora	30	9 Brahmins.
Bangalore	...	
Belgaum	...	
Benares	11	6 Brahmins.
Burdwan	...	
Calcutta	...	
Calicut	...	
Cawnpore	3	3 Brahmins.
Conjeeveram	...	
Darjeeling	...	
Dehra Dun	1	
Delhi	1	
Dharmasala	...	
Fyzabad	1	1 Brahmin.
Gwalior	3	1 Brahmin.
Gya	5	2 Brahmins.
Hyderabad	...	
Jubbulpore	1	1 Bania.
Jummoo	...	
Kapurthalla	4	

Table I—continued.

Number of Lepers who denied having ever eaten fish.

ASYLUM OR LOCALITY.	No. of persons who never ate fish.	REMARKS.
Lahore	...	
Lucknow	...	
Madras	1	
Madura	1	1 Brahmin.
Mandalay	2	2 Brahmins.
Meerut	...	
Moulmein	1	
Nagpur	3	3 Brahmins.
Naini and Allahabad	1	1 Brahmin.
Nairi Tal	...	
Patiala	5	2 Brahmins; 1 Bania.
Peshawar	...	
Poona	3	1 Brahmin.
Prome	...	
Purulia	...	
Rangoon	...	
Rawalpindi	30	1 Brahmin.
Sialkot	15	
Subathu	5	5 Brahmins.
Tanjore	...	
Tarn Taran	8	

Table I.—concluded.

Number of Lepers who denied having ever eaten fish.

ASYLUM OR LOCALITY.	No. of persons who never ate fish.	REMARKS.
Thayetmyo	...	
Trichinopoly	...	
Umballa	14	1 Brahmin; 1 Bania.
Yerrowda Prison	3	1 Brahmin.
TOTAL	162	41 Brahmins and 8 Banias

The leper asylums of Almora and Dehra Dun are occupied by residents of the Himalayan hill tracts of Kumaun and Garhwal. The great elevations at which many of the villages in these tracts are situated, and their remoteness from rivers and streams, make fish a very rare article of food among the people. Some indeed have never seen it. A careful enquiry was therefore made from the leper residents of the asylums quoted, and the result is given in the subjoined table:—

No. of Cases examined.	A TE FISH			
	Habitually.	Occasionally.	Very seldom.	Never.
200	39	57	58	46

It will be seen from this table that 23 per cent. of well-marked lepers had never tasted fish, while a very large number only used it now and then. This is quite in accordance with local opinion on the subject, not only in Kumaun and Garhwal, but also in Kashmir, where leprosy is common among the Gujars, a people in whose dietary this article of food seldom finds a place.

It is not within the limits of mathematical probability that the statement of all these people should have been intentionally

or unintentionally incorrect, and the onus of proof, therefore, may fairly be considered to lie with them who discredit the statements of all patients alike.

There is thus, in the opinion of the Commission, no doubt that the consumption of fish is not the cause of leprosy. The fact that a fair number of cases of leprosy exists amongst people who have never touched such food argues sufficiently strongly against the exclusive fish hypothesis as above stated.

Salt also has been mentioned in connexion with leprosy, though by laymen rather than scientific writers. Mr. Conybeare during the early part of this year asked the Under-Secretary of State for India in the House of Commons "whether in the Presidencies of Madras and Bombay the price of salt has risen from 9 annas and 8 annas per maund in 1800 to Rs 2-11 and Rs 2-8 in 1890 respectively; whether he can state the facts, as to the increase or otherwise, in the price of salt for the other presidencies during the same period; whether in India the average consumption of salt per head for all purposes is only 10lb, while in the United Kingdom it is 72lb; whether it be a fact that leprosy has also increased during the same period; and whether the Government will direct the special attention of the Medical Commission on Leprosy in India to an investigation of the apparent connexion between the want of cheap salt and the spread of leprosy."

Accordingly special attention was paid to this subject, and, as far as possible, the most accurate information obtained. For the financial and statistical data regarding the price and consumption of salt the Commission are indebted to Mr. J. E. O'Connor, Assistant Secretary of the Government of India in the Department of Finance and Commerce, and they gladly here give expression to their obligation to him.

For the present argument, that is the relation between the want of cheap salt and the spread of leprosy, it will not be necessary to go further back than 1861. It is true that in the following provinces, *viz.*, Burma, Rajputana, Central India,

Bombay, Sind and Baluchistan, Nizam's Territory, Madras, Mysore, and Coorg, in the decennial period of 1861-70 salt was cheapest, and has risen in price during the two succeeding decennial periods, and in some instances has done so to a considerable degree. On the other hand, in Assam, Bengal, North-Western Provinces, Oudh, Punjab, Central Provinces, and Berar, salt has steadily become cheaper.¹⁷

Thus, if there be any connexion between leprosy and salt, the best means are given for studying such connexion. For if the spread of the disease depend on want of salt it should have been much more rapid throughout the first mentioned provinces. Before proceeding to the discussion of this point, a few words must be said as to the average consumption per head of salt in India.

The total quantity of salt passed into consumption during 1890 last year amounted to 2,801,800,000 lb. There is, however, also a considerable quantity of salt made in Burma, of which no exact account is kept, but this is estimated at (at least) 41,143,000 lb. There is, again, a considerable quantity manufactured from saltpetre, and some not inconsiderable quantities made in Native States. Adding all this to the quantity of which there is an account, and making allowance for quantities illicitly made and consumed, there cannot be less than 3,000 millions of pounds for the population of 286,697,000, or between 10 and 11 lb per head: 11 lb being perhaps the more accurate estimate.

Now, in comparing this with the 72 lb per head in the United Kingdom, it must be remembered that in India this salt is used almost exclusively for personal consumption, very little being employed for cattle and economic or industrial purposes. Again, the majority of people being vegetarians salt is not in so great demand as in Great Britain and Ireland, nor, owing to

⁽¹⁷⁾ "Prices and Wages in India," compiled in the Statistical Branch of the Finance and Commerce Department of the Government of India: Eighth Issue; pages 86-93.

the manner in which food is eaten, is there such a waste of salt in India.

Between 1870-71 and 1880-81 the consumption of salt increased by 19 per cent., and during the next ten years the increase was 21½ per cent. The increase of population in each decade is about 10 per cent., so that the ratio of increase in the consumption of salt was about twice as great as the ratio of increase in the population. And as the consumption is almost entirely human, it seems evident that if the people had enough salt twenty years ago, they have more than enough now.

In the interior of the Himalayas the price of salt is very high, not on account of the duty, for the salt consumed there is imported across the frontier duty-free, but as a result of the cost of transit. Excluding such exceptional tracts as Kumaun, Garhwal, and the Naga Hills, where the price of salt may be said to be about 7 seers to the rupee (about 2¼ annas per seer), the highest price of salt in India anywhere is 8 seers per rupee (or 2 annas per seer). The consumption per head being 11 lb, the annual cost of salt per head is equal to 11 annas, less than one anna (exactly eleven pie) per month. The average price may, however, be taken to be about 10 seers to the rupee, and the annual cost per head at this rate is under 9 annas, or about 9 pie per month. It may be assumed that the highest cost per head is one anna monthly, which is less than one penny at the present rate of exchange. This is an extreme and exceptional price, for salt ranges at about 8 seers to the rupee in comparatively but few places.

Now while discussing the assumed connexion between salt and leprosy, it is necessary to enquire whether the price of this article prevents the native from procuring the amount of salt required to keep his body in proper health. It is difficult to say exactly how much salt a working man actually requires. It is certain "that the various saline matters are

essential to health, that when they are not present in proper proportion nutrition is affected, as is shown by certain forms of scurvy: the peculiar dependence of proteid qualities on the presence of salt is proven, but beyond this very little is known."¹⁸ Klein and Verson also have shown that a total abstinence from salt causes an appreciable loss of weight, that is, disturbances in the animal metabolism.

The best authorities on dietetics prescribe a daily allowance of 300 to 460 grains of salts, but this includes the sum total of all saline matters necessary for nutrition.¹⁹ Hence 100 to 200 grains of sodium chloride might be considered a fair daily allowance. The prison allowance of salt for adult labouring prisoners in the North-Western Provinces and Oudh is 100 grains daily, being at the rate of $4\frac{3}{4}$ lb per annum. In the Punjab the allowance is a quarter of an ounce, or $5\frac{7}{8}$ lb per annum. In Bombay, the Central Provinces, Burma, and Assam the allowance is half an ounce, or about $11\frac{1}{4}$ lb per annum, while in Bengal and Coorg it is $14\frac{1}{4}$ lb per annum. In Madras, finally, the daily rate varies from half an ounce in the district prisons to an ounce in the Central Gaols, undoubtedly an unnecessarily large allowance. The scale varies with the diet of the prisoners, being highest in the rice-eating provinces, where also the consumption of salt by the population outside the prisons is largest. In the North-Western Provinces and Oudh, where the allowance is $4\frac{3}{4}$ lb in the prisons, the consumption of salt per head throughout the province is about 8 lb per annum, and it is much the same in the Punjab. And it is remarkable that though in the former provinces the price of salt has since 1871 decreased about 50 per cent., yet the annual consumption per head has remained almost stationary. The non-criminal population includes, it must be remembered, a large number of children, and allowance being made for these, the consumption

(¹⁸) M. Foster : A Text-book of Physiology : Third Edition, 1879, page 420.

(¹⁹) M. Foster : *op cit.*, page 411.

per head of adult population in most districts is very much in excess of the prison allowance which experience has proved to be ample.

Now, as it has been shown that 9 annas, even when the salt is most expensive, will buy the native all the salt he requires for his own personal use during the year, it cannot be said that the high price of this article debars him from obtaining his necessary supply of salt. So, if there be any causal connexion between salt and leprosy, there is no reason why the native should go without his salt, as a few pence will procure his annual demand for it.

The best mode of showing that such a connexion between leprosy and the price of salt does not exist is a comparison of the leper returns for the three censuses of 1872, 1881, and 1891 side by side with the prices of salt during the decennial periods preceding the enumeration. This is done in Table II.

Under "A" all those provinces and divisions are given where, with the exception of the north-western division of the Punjab, the price of salt has steadily diminished, while under "B" those districts are found where the conditions are reversed. It will be seen that the figures do not establish any causal connexion between a high price of salt and leprosy, since from the statistics no relativity can be established. *The want of salt, therefore, cannot, in the opinion of the Commissioners, be held responsible for the origin or maintenance of the disease.*

To illustrate this statement more graphically two maps have been constructed. In the former the districts where the price of salt has risen have been coloured red, blue indicating a fall in the rates. Similarly, in the other map, red denotes an increase in the leper ratios since the first census, and blue a diminution. If there were any actual connexion between the price of salt and leprosy, the colours in the two maps ought to correspond. It will, however, be seen that they almost replace each other.

TABLE

Relation between Leprosy

A

Province.	Division.	Salt (from 1861-70) No. of seers per rupee.	Proportion of lepers per 10,000 (Census 1872).	Salt (1871-81) No. of seers per rupee.	Proportion of lepers per 10,000 (Census 1881).	Salt (1881-90) No. of seers per rupee.	Proportion of lepers per 10,000 (Census 1891).
Assam	Surma Valley . .	7'90	1'6	8'41	7'3	10'69	13'2
	Brahmaputra Valley	2'07		7'24	7'0	9'60	11'7
Bengal	Eastern . . .	8'18	3'2	8'20	5'5	10'59	4'3
	Deltaic . . .	8'76	6'1	8'84	7'1	11'28	5'2
	Central . . .	8'39	16'2	8'54	19'0	11'13	16'0
	Northern . . .	7'71	7'8	7'69	11'8	10'78	5'3
	Orissa . . .	9'45	2'9	9'81	12'5	11'72	11'2
	Chota Nagpore .	6'16	2'5	6'95	5'3	9'07	4'4
	Behar, South . .	8'31	5'9	8'10	7'7	10'90	5'6
North-Western Provinces.	Behar, North . .	7'75	2'6	7'69	4'5	10'62	3'6
	Eastern . . .	6'8	2'4	7'73	3'1	10'04	2'6
	Central . . .	6'88	3'4	9'32	3'5	11'43	2'2
	Western . . .	7'36	2'5	9'67	2'4	11'80	2'1
Oudh	Sub-montane . .	7'08	2'9	8'49	4'3	11'04	3'6
	Southern . . .	6'50	7'0	7'90	3'3	10'31	3'8
Punjab	Northern . . .	6'78	6'9	7'89	3'5	10'65	3'9
	Southern . . .	7'99	5'2	9'34	2'7	11'66	1'7
	Central . . .	8'25	4'1	8'92	2'4	11'86	'9
	Sub-montane . .	9'50	8'8	9'88	4'6	13'57	2'5
	North-Western .	25'86	6'4	23'18	3'6	22'86	2'0
Central Provinces.	Western . . .	10'67	2'2	15'04	1'3	21'49	'5
	Central . . .	7'09	4'1	8'82	8'5	10'27	Returns not received
	Eastern . . .	5'56	1'7	7'77	4'5	9'67	
Berar	Berar . . .	6'71	3'6	7'58	7'7	9'04	
Berar	Berar . . .	9'26	6'4	8'85	14'0	10'36	12'7

II.

and the Price of Salt in India.

B

Province.	Division.	Salt (from 1861-70) No. of seers per rupee.	Proportion of lepers per 10,000 (Census 1872).	Salt (1871-81) No. of seers per rupee.	Proportion of lepers per 10,000 (Census 1881).	Salt (1881-90) No. of seers per rupee.	Proportion of lepers per 10,000 (Census 1891).
Burma	Tenasserim . .	39'12	12'3	29'82	4'2	20'21	2'6
	Pegu (deltaic) .	22'82	14'2	24'14	9'6	21'63	8'1
	Pegu (inland) .	31'34	11'8	23'39	6'9	14'19	6'5
	Upper Burma (Mandalay) .	...	...	...	...	19'03*	15'9
Rajputana	Arakan . . .	48'32	3'8	35'1	2'3	30'48	2'7
	Eastern . . .	...	...	23'48	...	12'46	'7
Central India.	Western . . .	...	...	48'47	...	15'93	2'3
	Indore, Neemuch Cantonment, and Gwalior . .	...	...	14'88	...	11'32	...
Bombay	Konkan . . .	16'85	8'6	14'20	7'6	12'04	7'5
	Deccan . . .	15'95	10'8	12'71	6'7	11'65	6'8
	Khandesh . . .	13'0	13'1	12'90	11'2	13'19	8'8
	Gujarat . . .	17'94	5'4	16'51	2'8	13'72	1'9
Sind and Baluchistan.	Kathiawar (Rajkot) .	...	...	50'69	2'2	40'06	1'5
	Kurrachee, Hyderabad, Shikarpur, Upper Sind Frontier, Quetta .	36'45	1'3	31'33	1'1	12'83	'7
Nizam's Territories.	Secunderabad, Bolaram . . .	12'51	...	9'88	...	9'86	...
Madras	Malabar Coast .	18'37	6'6	14'23	6'3	13'62	5'6
	South, Central .	15'86	2'5	14'26	2'8	14'09	'8
	Central . . .	13'16	3'4	15'44	2'5	13'46	1'5
	East Coast, North .	18'82	4'0	14'61	4'9	12'8	4'8
	East Coast, Central .	19'07	3'7	15'93	3'6	13'9	2'7
Mysore	East Coast, South .	19'02	5'8	15'82	5'9	14'24	4'2
	Southern . . .	18'	2'9	15'69	4'1	15'5	2'1
Coorg	Mysore, Bangalore .	13'4	4'9	10'82	2'6	9'96	3'4
	Coorg . . .	13'57	4'8	9'47	2'4	9'9	1'3

* Average of period from 1887 to 1890.

Lastly, water has been considered to be the vehicle of the leprosy bacillus, and thus a means of infection. In some parts of India this is a popular idea, and according to Boinet²⁰ a similar opinion is held in certain parts of China. The theory seems, however, highly improbable. For whether it be assumed that leprosy bacilli contained in the water enter the body by the mouth or through the broken cuticle, on such hypothesis the disease should be much more generally diffused throughout the empire than it actually is. The tanks in India, filled with more or less stagnant water, are frequented by all classes of people, and the leper is by no means everywhere prevented from bathing with the rest, or filling his lota side by side with a healthy person. He also attends "Melas," and bathes in the company of other pilgrims. Any one who has witnessed the life around the tanks will easily conceive that a disease, if spread by means of water, should be diffused to an alarming extent and at a great rate, especially if such disease be endemic and always present.

It seems, moreover, very improbable that the leprosy bacillus is capable of multiplying outside the human body. It is, however, quite possible that, like the tubercle bacillus, it remains dormant for a long time after leaving its host. But the above considerations point strongly against the supposition that it exists in ordinary water in this condition. Besides the bacillus has never been found in water, and the observations of the Commissioners were absolutely negative in this respect. They examined water from the tank at Tarn Taran, which is supposed to be beneficial to lepers, and is, therefore, always thronged by them. Yet, as will be seen from the Laboratory Report, although a large number of microscopical specimens were prepared, in not a single instance could the leprosy bacillus be detected. *Water, therefore, can hardly be held responsible for the propagation of leprosy.*

(²⁰) E. Boinet: La Lèpre à Hanoi (Tonkin). Revue de Médecine, X, No. 8.

Enquiry has been frequently made from intelligent native gentlemen, as well as from patients, as to certain habits and influences which might be concerned in the origin and propagation of leprosy. No instance of the transmission of the disease from an animal to man was met with. Leprosy must be considered exclusively a human disease, and it does not attack domestic or other animals, as is the case with tubercular disease.²¹ The effects of premature marriages and the consumption of opium, alcohol, and other stimulants were also enquired into, but with entirely negative results. And indeed, though undoubtedly certain classes indulge to excess in opium, tobacco, the various forms of Indian hemp, alcoholic preparations from sugar, "mhowa," and the toddy palm, etc., the races of India must be regarded upon the whole as decidedly temperate.

Leprosy and Antecedent Diseases.

The question of the effect of syphilis was also considered. It seems that when syphilis first appeared it was thought by many to be a new form of leprosy, a modified leprosy. The reason for this belief was the fact that syphilis appeared in Europe about the same time when leprosy began to die out. The leading physicians of that time, however, strongly contested such views. The people were so convinced of the erroneousness of this theory that the lepers refused to admit syphilitic patients into their hospitals, and the latter had to build special hospitals for themselves.²² "And as leprosy became more and more an unknown disease, partly speculation, partly the observation of certain endemic syphilides, led some physicians back to the ancient supposition."²³

At the present time some authorities have propounded the converse theory that leprosy is an effect of syphilis, a modified

(²¹) Cf. Journal of the Leprosy Investigation Committee, No. 2, February 1891, page 130.

(²²) R. Virchow: op. cit., pages 500 and 501.

(²³) *Ibidem.*

syphilis. There can be no doubt that syphilis pathologically is nearer related to leprosy than any other affection.²⁴ This, however, is no justification for the more modern theory. In fact, as far as local changes are concerned, an almost greater resemblance exists between lupus and leprosy.²⁵ Yet no one has ever ventured to identify these two affections with one another.

Sir W. J. Moore's name is closely associated with what might be called the syphilis-hypothesis. He considers leprosy a phase of inherited syphilis.²⁶ In the opinion of the Commissioners this view cannot be supported for the following reasons: (a) the history of this hypothesis, as briefly alluded to above, is entirely against it; (b) there is at most only a resemblance or analogy traceable between the two diseases; (c) certain clinical facts absolutely disprove the theory, unless the present views on syphilis be entirely modified or in part given up. The fact that people contract syphilis after having become affected with leprosy, is quite irreconcilable with the theory under consideration that leprosy is a phase of syphilis: and it matters little whether it be congenital or acquired. Of 154 individuals who confessed to having suffered from syphilis, 12 had been thus affected after the appearance of leprosy. At a few asylums every leper was consistently interrogated with a view to obtaining a more or less reliable ratio of syphilis amongst lepers. Out of 458 lepers examined 88, or 19.2 per cent., were found at one time or another to have suffered from this disease. This percentage may appear high, but too much importance must not be attached to the figures as they stand. In the first place, the ignorance of the informants rendered it impossible to be sure that the disease they described was truly syphilis, and undoubtedly a certain number of cases must be deducted. Yet many of these lepers had the unequivocal marks of tertiary

⁽²⁴⁾ R. Virchow: *op. cit.*, pages 500 and 501.

⁽²⁵⁾ *Ibidem*.

⁽²⁶⁾ Journal of the Leprosy Investigation Committee, No. 1, August 1890, page 27, and "*Lancet*," May 17, 1890.

syphilis on their bodies. Again, no figures are obtainable showing the extent to which syphilis and venereal diseases prevail amongst the general population, though this is known to be very large. Lastly, it may be objected that in those instances where syphilis had been contracted subsequent to the development of leprosy, the ignorance of the informant rendered it difficult to decide with certainty as to which was the prior event. These concessions must naturally detract a great deal from the value of Table III. However, three authentic cases were seen by the Commissioners, where there could not be the slightest doubt that syphilis was contracted subsequent to the disease. These were all seen at the asylum in Madras. Two were young men who had suffered from leprosy for the last four and five years respectively: each of them had a typical roseolar secondary eruption, the characteristic appearances of the tongue, tonsils, and fauces, and moreover one of them presented the remains of a true Hunterian sore, while the other had lost the fraenum praeputii and showed an unmistakable scar. The third case concerned a low caste Hindu, twenty years of age, who had suffered from tubercular leprosy for the last twelve months and at the time of examination actually had a primary sore on the glans penis. These three instances alone are sufficient to destroy the syphilis-hypothesis.

TABLE III.

Relation of Syphilis to Leprosy.

ASYLUM OR LOCALITY.	SYPHILIS CASES.			REMARKS.
	Before Leprosy.	After Leprosy.	TOTAL.	
Agra	6	...	6	(1) Three cases contracted syphilis at about the same time they became lepers.
Aligarh	1	...	1	
Almora	7 ¹	1	8	

Table III—continued.

Relation of Syphilis to Leprosy.

ASYLUM OR LOCALITY.	SYPHILIS CASES.			REMARKS.
	Before Leprosy.	After Leprosy.	TOTAL.	
Bangalore . . .	1	1	2	
Belgaum . . .	2	...	2	
Benares . . .	3	...	3	
Burdwan . . .	5	...	5	
Calcutta . . .	10 ²	2	12	(*) One case contracted syphilis at the same time he became a leper.
Calicut . . .	1	...	1	
Dchra Dun . . .	5	2	7	
Delhi . . .	1	...	1	
Dharmasala . . .	4	...	4	
Fyzabad . . .	3	...	3	
Gya . . .	11	...	11	
Jubbulpore . . .	2	...	2	
Kapurthalla . . .	1	...	1	
Lucknow . . .	2	...	2	
Madras . . .	2	...	2	
Mandalay . . .	21	1	22	
Moulmein . . .	4 ⁸	...	4	(*) One case contracted syphilis about the time he became a leper.
Nagpur . . .	22	2	24	
Naini and Allahabad . . .	1	...	1	
Naini Tal . . .	1	...	1	
Peshawar . . .	2	...	2	
Prome . . .	6 ⁴	...	6	(*) One case contracted syphilis about the time leprosy began.
Purulia . . .	4	...	4	
Rawalpindi . . .	1	...	1	
Sialkot . . .	1	...	1	
Tanjore . . .	1	...	1	

Table III—continued.

Relation of Syphilis to Leprosy.

ASYLUM OR LOCALITY.	SYPHILIS CASES.			REMARKS.
	Before Leprosy.	After Leprosy.	TOTAL.	
Tarn Taran . . .	2	...	2	
Thayetmyo . . .	6 ⁵	3	9	(*) One case contracted syphilis about the time he became a leper.
Trichinopoly . . .	1	...	1	
Umballa . . .	2	...	2	
TOTAL . . .	142	12	154	

Again, even allowing that a certain number of the 154 cases specified in Table III were instances of gonorrhœa, does not the fact that the remainder contracted syphilis at all—and many of them had undoubtedly done so—militate against Sir W. J. Moore's theory? For as these men became lepers they must have been born in the particular phase of congenital syphilis. How, then, is it to be explained that many of these men presented the typical signs of tertiary syphilis concurrently with those of leprosy?

Lastly, it has never been shown that syphilis passes into leprosy, or *vice versa*. Nor does syphilis ever modify the progress of the local changes in leprosy; and the converse also holds good.²⁷ In conclusion, all that has been said on heredity may be used as arguments against this hypothesis.

It is, therefore, impossible to regard syphilis as having any real or specific influence on the production of the disease, or as acting otherwise than by lowering the general tone of the system, and thereby rendering it more liable to attack by, or hastening the progress of, leprosy.

(²⁷) R. Virchow: *op. cit.*, page 501.

Other diseases have been considered the possible cause of leprosy, as malaria or scrofula. It is, however, so plain that there is no scientific evidence for such assumptions that mere mention of these hypotheses will suffice.

Summary.—The Commission have come to the conclusion, after full consideration of the circumstances of life of the average native of India, that neither the form of diet, nor the sanitary environment of the individual, have any specific action in the causation of leprosy. But, as will be seen from what has been written, sanitation in this country is far from satisfactory, and leaves very much to be desired in the way of improvement. And it is probable that bad hygienic surroundings, deficient or improper food, poverty, exposure, and such diseases as syphilis, are all factors of great importance in reducing the vital powers of the organism and rendering it more susceptible to attack. All such indirect and non-specific causes are specially operative in the case of the offspring of lepers, who are commonly beggars, and living under the most unfavourable conditions for health. Nothing has struck the Commission more forcibly during this enquiry than the improvement in the general health of the sufferer which follows residence in a well-conducted asylum, where cleanliness, regular diet, and sanitary principles are insisted upon and maintained.

CHAPTER VII.

The Treatment of Leprosy.

DURING the stay of the Commission in India little opportunity occurred of personally investigating the effect of treatment on leprosy, for only a short time was spent in any station except Simla, and the latter place was too far from a leper asylum to allow of systematic observations being made. Information as to treatment had, therefore, to be drawn from Indian and other Government reports, from various works on leprosy, and from replies of officers in charge of leper asylums, and of Civil Surgeons who had treated the disease in district hospitals and dispensaries.

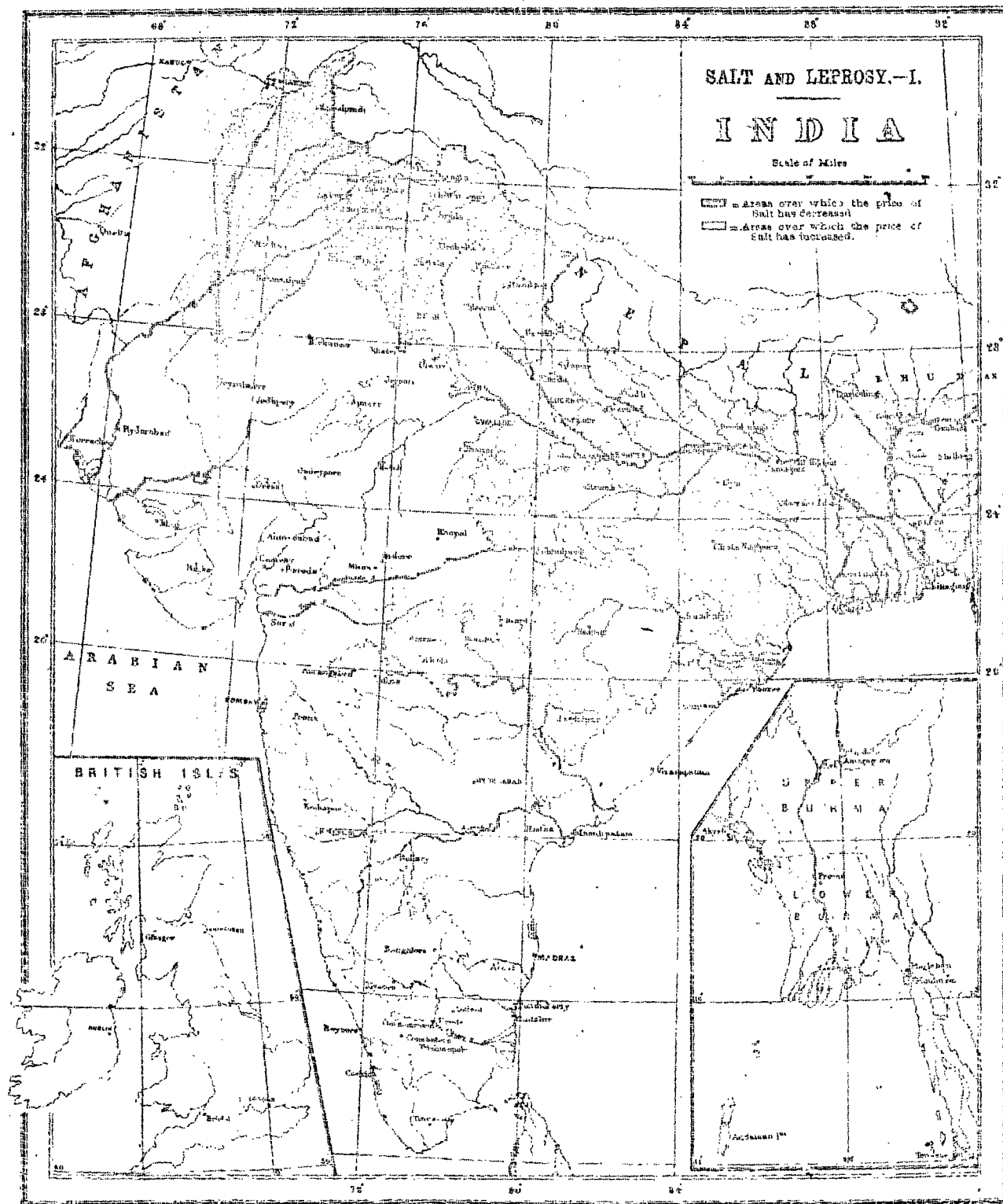
It has already been pointed out that the incurability of leprosy by any means yet known is unfortunately certain. The following remarks must, therefore, be understood to apply to palliative treatment.

This may be conveniently considered under three heads—

1. Hygienic.
2. Medicinal.
3. Surgical.

Hygienic.

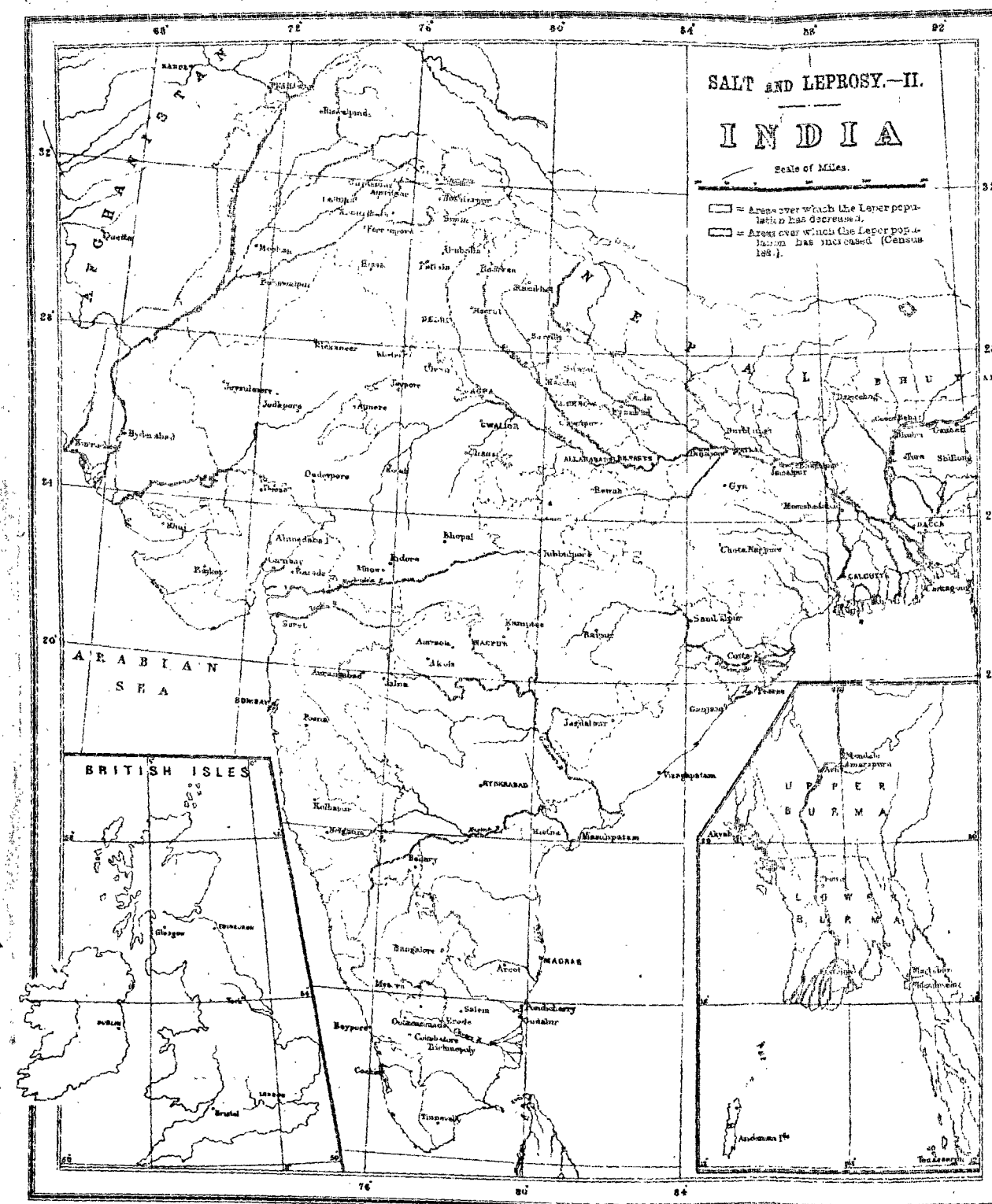
The amount of hygienic treatment possible naturally varies with the circumstances of the patient. What may be practicable for the rich man will be unattainable by the poor one. This is a truism for all diseases, but it is peculiarly applicable to leprosy. For example, it has been found beneficial in some cases of leprosy to remove the patient to a temperate climate where leprosy is not endemic. This proceeding is, of course, inapplicable to the great majority of Indian lepers, and can, therefore, be dismissed at once. Similarly, if all the lepers of India could be made to wash regularly, to live in roomy and



Reg. No. 455, Leprosy Com.—Sept. 91—315.

See No. 458 R, Leprosy Com.—Mar. 92—1,000.

Photo-litho, S. I. O., Calcutta.



Reg. No. 455, Leprosy Com.—Sept. 91—315.

Reg. No. 458 R, Leprosy Com.—Mar. 92—1,000.

Photo-litho, S. I. O., Calcutta.

well-ventilated houses, to eat only fresh and nourishing food, to engage in gardening or other healthy outdoor occupation as far as their crippled state would permit, and to observe the greatest care with reference to drainage and sewage disposal, there is no doubt but that their disease would run a much milder course. For this reason, apart from any question of segregation on other grounds, the establishment of voluntary asylums under careful supervision throughout India would do much to lessen the sufferings of the leper, for in them he would be taken away from his usual insanitary surroundings.

The difference between the condition of the lepers examined by the Commission in well-organised asylums, and that of outcasts, in many cases without home or friends, collected by the civil authorities, was sufficiently striking.

Medicinal.

Many drugs have been used in the treatment of leprosy and widely different opinions have been expressed as to their utility. The many secret remedies employed from time to time may be at once dismissed, for they cannot concern a scientific inquiry. Nor would space permit a dissertation on all the known medicines which have been given for leprosy. Only those will be discussed which have attracted attention, or which have appeared to be of some value.

The oils of India may be conveniently considered in the first place. Dr. George Watt¹ mentions the following oils as having been used in the treatment of leprosy—

- | | |
|--------------------------------|----------------------------|
| 1. Albizzia Lebbek. | 6. Hydnocarpus Wightiana. |
| 2. Anacardium occidentale. | 7. Hydnocarpus venenata. |
| 3. Cynometra ramiflora. | 8. Pongamia glabra. |
| — 4. Dipterocarpus turbinatus. | 9. Psoralea corylifolia. |
| 5. Gynocardia odorata. | 10. Semecarpus Anacardium. |

(¹) Dictionary of the Economic Products of India, Vol. IV, page 309; Vol. V, Part I, pages 462 and 463; Vol. V, Part II, page 354.

Dr. Vandyke Carter² also says that the oil of *Arachis hypogæa*, the ground-nut, has been used, but that its utility is not apparent.

Of the above eleven oils only four need be discussed at length. They are *Anacardium occidentale*, or Cashew-nut oil, *Dipterocarpus turbinatus*, or Gurjun or Kanyin oil, *Gynocardia odorata*, or Chaulmoogra oil, and *Hydnocarpus Wightiana*, or Kowti oil. They will be referred to in the order in which they occur on the list.

ANACARDIUM OCCIDENTALE.

This oil played an important part in the plan of treatment adopted by Dr. Beauperthuy at Cumana in Venezuela. Several cures having been alleged, Dr. Bakewell was deputed to examine and report on the cases treated. His official report was presented to both Houses of Parliament in 1871, and spoke highly in favour of the results obtained by Dr. Beauperthuy.

The main features of the treatment are these—

1. Hygienic Rules.

The patient must have pure air and nourishing food, including a moderate amount of fresh meat daily, with a sufficient quantity of fresh vegetables. He must abstain from salted meat or fish.

2. External Applications.

Frictions over the whole of the skin with cocoanut oil or olive oil are to be employed twice a day. These are to be followed by soap and water baths. The oil of cashew-nut is then applied by means of a small piece of sponge to the

(²) Reports on Leprosy, Second Series, page 33.

diseased parts. The skin must not be broken, and the exudation must be allowed to dry on, so as to form a crust. After about twelve days this will fall off, leaving the skin beneath clear and free from ulceration. It is not advisable to paint at one time an area greater than that represented by the skin of the leg or fore-arm. The applications should not be repeated at intervals of less than a week.

3. *Internal Medicines.*

These are perchloride of mercury in doses of one-fifteenth to one-twentieth of a grain twice a day for adults, and in cases where mercury is contra-indicated, sodium carbonate, given in doses of 10 to 20 grains twice a day.

There is no doubt that this was a rational mode of treatment, and one which afforded distinct relief to the patient. The mistake made was in regarding it as curative. Whatever merit the treatment possessed lay in the strict regimen which had to be observed by the patient, and in the attention to the functions of the skin which was insured by frequent baths and frictions. The oil of cashew itself merely acts as a caustic, and the same result can be less laboriously obtained in tuberculated leprosy by free excision of tubercles, as will be mentioned below.

The influence of the medicines given internally by Dr. Beauperthuy may fairly be disregarded. According to Dr. Bakewell a patient taking sodium carbonate progressed quite as favourably as one taking mercury perchloride.

Internal medication has always been the difficulty in leprosy. It is not hard to treat the skin complications and even to attain some measure of success, but so far no drug has been discovered which taken by the mouth will bear the relation to leprosy which mercury and potassium iodide bear to syphilis. Fresh crops of tubercles, or anæsthetic patches, soon make their appearance, and, as was the case at Cumana, the condition of

patients becomes as bad as, or even worse than, it was before they were treated.

DIPTEROCARPUS TURBINATUS.

The use of this oil in the treatment of leprosy was first recommended by Surgeon-Major J. Dougall³ at Port Blair, Andaman Islands. Two emulsions were made by direction of Dr. Dougall. The first was to be taken internally and consisted of three parts of lime water and one part of gurjun oil. The second emulsion for external use contained equal parts of gurjun oil and lime water.

The lepers rose every morning at daybreak and bathed, using dry earth as a detergent, so as to rub off the previous day's inunction. They afterwards drank half an ounce of the first emulsion. The second was then rubbed in for two hours. At 3 P.M. the same dose was given, and another two hours' friction practised.

Dr. Dougall tried the effect of this treatment on twenty-five lepers for a period of six months and says⁴: "The time has been long enough to show that leprosy, both tubercular and anæsthetic, can not only be arrested, but the condition of the lepers can be greatly ameliorated; and men here who have not for years been able to do more than drag out a miserable helpless existence are now able and willing to work, and every sore is quite healed."

This report was sufficiently encouraging to justify investigations into the gurjun oil treatment of leprosy. The Madras Government in the course of the next year published an account of the results obtained with gurjun oil in the hospitals and asylums of that Presidency. Surgeon-General E. G.

⁽³⁾ Surgeon-Major J. Dougall, M.D. Report on the Treatment of Leprosy with Gurjun oil. Calcutta, 1875: page 6.

⁽⁴⁾ Op. cit., page 14.

Balfour, in his covering letter, arranges the medical reports in three groups⁵—

- (1) *Those of officers in charge of the three Leper Hospitals.*—In these reports the opinion is expressed that the oil does not possess any particular efficacy;
- (2) *Those of officers in charge of Civil Dispensaries and Gaols.*—These on the whole are favourable, and several cases of improvement are reported;
- (3) *Those of Regimental Medical Officers.*—The cases under this head are necessarily few, as declared leprosy is considered to unfit the subject for further service and he is discharged. Gurjun oil is reported to be useful in alleviating the more prominent symptoms of leprosy, and one case is said to have been cured.

On the whole, Dr. Balfour considers the results of the trial of gurjun oil to be encouraging, but points out that in the supposed cases of cure it will be necessary to watch the future medical history of the patient.

In Dr. Watt's Dictionary⁶ a summary is given of answers received from nineteen medical men in India who were specially questioned as to the utility of gurjun oil in leprosy. Of these answers thirteen were positive, three negative, and three neutral.

Answers were received by the Commission from a large number of stations in which gurjun oil had been used for leprosy. Many of these answers reported that more or less relief had been obtained, but in no instance was there any allusion to a cure. In some cases the relief afforded was very slight. From other stations the answers stated that no effect

(⁵) Report on the Treatment of Leprosy with Gurjun oil and other Remedies in Hospitals of the Madras Presidency. Madras, 1876: page ix.

(⁶) Op. cit., Vol. III, page 169.

whatever had been observed. Some answers were neutral, the patients having disappeared from observation, or the time during which they had been under treatment having been too short to draw conclusions as to the efficacy of the oil.

Dr. Hillis, who tried this treatment in the Mahaica Leper Asylum, says⁷: "I can claim for gurjun oil that, given a suitable case, the disease can be arrested by it, and that in a few instances there has been no return of the disease for over two years, but it may nevertheless be premature to say a cure has taken place."

This experience was not borne out in the Trinidad Asylum,⁸ where a trial of the oil showed only such temporary relief as would follow frictions with cocoanut oil or any other simple application.

Dr. Vandyke Carter⁹ also failed to find that gurjun oil exerted any specific effect on the course of leprosy. He used the drug internally and externally in selected cases for months, without obtaining any perceptible improvement.

From the above review of the various trials which have been made with gurjun oil, it appears that though a certain amount of temporary relief may follow its use, it is very doubtful whether this is more than can be obtained with any common oil. Dr. Dougall's success at Port Blair was probably due to the fact that he was dealing with a colony of convict lepers under prison discipline, and was, therefore, able to carry out his plan of treatment far more rigorously than in an asylum where, as a rule, patients are averse to any therapeutic measures which involve the least exertion. It is quite possible that the prolonged frictions with dry earth, and the regular sea-bathing, were quite as potent in affording relief as the use of the gurjun oil.

(⁷) Leprosy in British Guiana, page 224.

(⁸) Report on the Trinidad Leper Asylum for 1884.

(⁹) Reports on Leprosy, Second Series, 1876, page 36.

GYNOCARDIA ODORATA.

This oil has long been known in the East as a remedy for leprosy, but it is only of late years that it has attracted notice in Europe. Like gurjun oil it is used both internally and externally.

Of eight answers recorded by Dr. Watt¹⁰ from medical men who had used chaulmoogra oil in leprosy, four were favourable, two denied that any result was obtained, while two were neutral and expressed no opinion as to the value of the oil.

Dr. Vandyke Carter¹¹ selected cases for treatment with chaulmoogra oil and arranged them under as follows:—

- (a) Young fairly nourished subjects with early disease. In them the result was decidedly beneficial.
- (b) Confirmed, but not disabled lepers. The effect of the oil on these was moderately beneficial.
- (c) Confirmed, disabled, or broken-down subjects. No result was obtained in these patients.

Dr. Carter goes on to say that the longer the oil is used, the more favourable will the result be, both in degree and permanence. The good effect may last for three, four, or five years after prolonged use of the oil, but the disease is never eradicated even in the most suitable cases.

Of the first forty-seven answers received by the Commission from asylums and stations in which chaulmoogra oil had been used, thirty reported more or less relief after the use of the oil. In some the relief was very slight, while in others the disease was said to be arrested. In no case was a cure reported. From twelve stations the reports showed that there was no effect after chaulmoogra treatment, while five answers did not express an opinion one way or the other.

⁽¹⁰⁾ Op. cit., Vol. IV, page 194.

⁽¹¹⁾ Op. cit., page 34.

Mr. Sakharam Arjun,¹² who was in charge of the ward for incurables in the Jamsetjee Jeejeebhoy Hospital, Bombay, gives his opinion of the value of chaulmoogra oil as follows:—

"Under the prolonged and continuous use of this oil the progress of the disease is arrested, the skin becomes soft and supple, the discolorations vanish, the different morbid sensations leave the patient, the mental hebetude passes away, the impaired sensibility is completely or partially restored, the ulcers heal and cicatrise though ever prone to break out again, and the general nutrition of the tissues improves, patients crippled before being known to walk about unassisted and to gain in strength and weight."

In the Trinidad Leper Asylum¹³ many of the more intelligent patients asked for chaulmoogra oil of their own accord and continued its use for several months.

One man used the oil internally and externally for seven years. The tubercles disappeared from his face and extremities and the anæsthesia was lessened.

The fact that these lepers persevered in any plan of treatment is in itself strong presumptive evidence that they derived some benefit from the drug employed, for, as was pointed out earlier in this chapter, such patients soon tire of any systematic medication.

The chief results obtained in eighteen cases were—

1. Increase of perspiration.
2. Decrease of tubercles.
3. Improved appetite and sense of well-being.
4. Increase of sensation.
5. Increased suppleness of skin and lessening of pains in joints.

A similar result was observed in a highly intelligent private patient who had taken chaulmoogra capsules for six years, and who had also tried residence in Europe. At one time he

⁽¹²⁾ Report on Leprosy, 1873.

⁽¹³⁾ Report on Trinidad Leper Asylum for 1889, pages 11 and 12.

took seventy-five drops of the oil a day. When last seen the face was clear, but there were one or two nodules in the lobes of the ears, and a few small reddish patches on the thighs. The intervals between the tubercular outbreaks were much greater, and the patient was able to do a great deal of riding.

From the above experiences derived from various sources it seems that the action of chaulmoogra oil in leprosy, though at the best palliative, is nevertheless more marked than that of gurjun oil. Indeed it is probable that a prolonged and regular use of this oil may in some cases arrest the progress of the disease, though for how long must still be doubtful.

HYDNOCARPUS WIGHTIANA.

This oil was employed together with chaulmoogra oil in the treatment originated by the late Mr. Bhao Daji, which attained such notoriety in Bombay about twenty years ago. Apparently the first results obtained were encouraging, but Dr. Vandyke Carter,¹⁴ who was living in Bombay at the time, and who had, therefore, ample opportunities of observing the effect of this treatment, writes as follows:—"I have before me notes of three or four cases which were duly treated here, and in none has a cure been effected, for either no good whatever resulted, or the symptoms are simply quiescent." Dr. Carter, however, considers that kowti oil is a useful aid in the treatment of leprosy.

The most noteworthy oils used in the treatment of leprosy have now been discussed. From what has been said above it will be evident that any oil which is thoroughly rubbed into the skin may afford more or less relief. Hence it will not be necessary to discuss the other seven oils mentioned at the beginning of this section, for no specific action can be claimed for any of them.

(¹⁴) Reports on Leprosy, Second Series, 1876, page 36.

Two common Indian plants, which have attained a considerable reputation in the treatment of leprosy, may here be mentioned. They are the Madar (*Calotropis gigantea*) and the Asiatic Pennywort (*Hydrocotyle Asiatica*). From evidence collected, however, it appears that their value has been overstated.¹⁵ The first is said to be temporarily useful as a tonic in recent cases of leprosy, while the stimulant effects of the second on the circulation are most marked in the preliminary anæsthetic stages of the disease. These drugs have clearly no specific action in leprosy.

Arsenic is a drug which has been largely used in the treatment of leprosy, and sometimes with good result. Dr. Bowerbank¹⁶ writing from Jamaica says: "In only one case did medical treatment seem to keep the disease in check. During eighteen or twenty years the patient, a female, had repeated attacks of apparently intermittent fever, and on each occasion the characteristic spots made their appearance; she had also anæsthesia and slight enlargement of the eyebrows and lobules of the ears. The use of Fowler's solution always checked the disease."

Dr. W. Nicholson¹⁷ of Antigua also remarks: "Arsenic is the only remedy which in my practice has had any effect in arresting the disease, and that only for a time. I have seen the tubercles disappear under its use, sensation restored to fingers that were incapable of feeling and using a needle, so that the patient was enabled to sew, yet the disease returned and proved fatal."

In the Trinidad Asylum¹⁸ arsenic was given during several months to two lepers who were particularly subject to frequent acute outbreaks of tubercles. One of these patients was

(¹⁵) Dictionary of the Economic Products of India, by Dr. G. Watt, Vol. II, page 45, Vol. IV, page 313.

(¹⁶) Report on Leprosy by the Royal College of Physicians, 1867, page 14.

(¹⁷) Op. cit., page 21.

(¹⁸) Report on Trinidad Leper Asylum, 1884.

German, the other a slightly coloured Barbadian. Both had very delicate skins, and the result observed after prolonged treatment with liquor arsenicalis was a very marked diminution in the frequency of the tubercular eruptions. The German, in fact, was free from an attack for about a year, whereas before he began taking arsenic the exacerbations had occurred at intervals of a few weeks.

The use of ichthyol and resorcin in the treatment of leprosy was recommended by Dr. Unna of Hamburg in 1886. Since that time they have been used in various parts of the world, but the results obtained have hardly fulfilled expectations. It is true that many of the cutaneous complications of leprosy may be relieved or removed by the use of these drugs, but the same result can be obtained with a simple application such as vaseline. Ichthyol and resorcin have lately been issued by the Government for trial in the various Indian stations. Reference to the table at the end of this chapter will show that little effect has followed their use in leprosy.

Still more recently Dr. Lutz in Hawaii has brought to notice a new group of drugs for the treatment of leprosy. In a report, dated June 30th, 1890, he says: "In general we have had no instance of the disease making progress in patients treated by the most efficacious means, that is, salol and salicylate of soda internally, and chrysarobin and pyrogallie acid externally."

Some members of the Commission tested the action of salol on two lepers in Simla who happened to present themselves for treatment, but observed no result. Surgeon-Major H. D. Cook kindly treated a number of patients in the Madras Leper Asylum with salol, and his report is appended.

From an ambulatory treatment little or nothing could be expected, as this naturally excludes all clinical observation. Dr. Cook's verdict confirms the opinion of Dr. Lutz, that as a palliative, salol is of decided value in leprosy. The results, even after a course of five weeks, are so promising that the treatment is being continued at the Madras Asylum. No doubt,

prolonged and critical observation is necessary before a decided opinion can be given; and this Dr. Cook has fully realised. There can, however, be no question as to the temporary benefit derived from the salol treatment. Doses of twenty grains were given three times a day for two weeks, and then increased to thirty grains three times a day. Apparently large doses must be given for a long time. Most of the cases subjected to the treatment suffered from tubercular or mixed leprosy. The greatest testimony in favour of the drug is, that the patients professed to feel better and gladly persisted in the treatment, while the native as a rule is easily disheartened and will not subject himself to therapeutic measures which after a short trial give him no relief. Bad effects were hardly ever observed, even after large doses of salol. On the other hand, tubercles seem to decrease in size, ulcerate, and then subside or heal up: a fresh crop of tubercles follows and goes through the same phases. Sensation was often restored, and anæsthetic areas, in fact, at times became hyperæsthetic; patches improved in colour, and the scaly, shiny appearance of the skin which is so characteristic of certain forms of leprosy, assumed a healthier look, and the skin became moist and more sensitive. The general condition of the patient often improved greatly.

With such favourable results after so short a period, it is justifiable to persevere. Accordingly Dr. Cook is continuing the treatment, and thus better means will be given to fully estimate the value of salol. If future experience confirms these early observations, then Dr. Lutz has indeed found in salol a valuable drug for the palliative treatment of leprosy.

A brief allusion only need be made to such drugs as perchloride of iron, potassium iodide, and cod-liver oil. These are often very useful adjuncts in the treatment of leprosy, but their action is exactly the same as in other diseases. Mercury may be used when the leper is suffering from syphilis. The latter disease will be rapidly brought under control, while the leprosy remains uninfluenced. The risk of giving mercury in

leprosy, which some writers have insisted on, appears to be overrated. There is no doubt that with ordinary care this drug may be as freely given in leprosy as in any other disease.

From the above evidence it would appear that chaulmoogra oil and arsenic are the most valuable drugs at present known for the palliative treatment of leprosy; and if further experience and observation justify the hopes expressed by Dr. Cook at the beginning of his treatment of lepers with salol, then the latter must rank high among the drugs used and given for the amelioration of the general and local condition of these patients. It must, however, always be remembered that spontaneous subsidence of tubercles, or even arrest of the disease, may take place without any treatment, hence it is always difficult to estimate the part contributed by drugs to any good result which may follow their use.

Surgical.

Much may be done to relieve the leper by surgical interference. It may be stated as a general rule that any operation which would be undertaken on another patient may be performed on one suffering from leprosy. The rapidity with which the tissues of lepers heal after operation is remarkable. This may, perhaps, be due to the excess of fibrin which has been found in the blood of these patients, a fact which was first pointed out by Danielssen and Boeck,¹⁹ and which has since been confirmed by Hillairet²⁰ and at the Trinidad Asylum.²¹ In the last-named institution an examination of the blood of fifty lepers, tuberculated, anæsthetic, and mixed, showed the average quantity of fibrin to be .7 per cent.

An operation which has attracted considerable attention as a means of treatment in leprosy is nerve-stretching. This has yielded good results as practised by Surgeon-Major Lawrie,²²

⁽¹⁹⁾ *Traité de la Spedalskhed.* Paris, 1848.

⁽²⁰⁾ *Annales de Dermatologie et Syphilographie.*

⁽²¹⁾ Report on Trinidad Leper Asylum for 1887.

⁽²²⁾ *Lancet*, 1881.

and by Drs. Downes,²³ Neve,²⁴ Mitra,²⁵ and others in India. In Trinidad²⁶ out of one hundred cases operated on, more or less relief was obtained in about half. The chief results noticed were relief of pain in the course of the nerves operated on, healing of perforating ulcers in the area supplied by these nerves, and, more rarely, some decrease of anæsthesia. Unfortunately none of these effects were permanent, and the operation had sometimes to be repeated on the same nerve. There is no doubt, however, that nerve-stretching is a valuable aid, especially in the treatment of the distressing neuralgia which often complicates leprosy. But the operation cannot be claimed as in any way curative.

Free excision of cutaneous tubercles is a procedure which is followed for a time by good results, and if a drug could be found which given internally would prevent recurrence of these growths, there would be a fair hope of ultimate success.

By cutting deeply it is possible to eradicate single tubercles or circumscribed masses of tubercle and to obtain a clean cicatrix, but after a few weeks or months the growths begin to recur in the sound skin around these cicatrices, and the patient relapses as rapidly as after the Beuperthuy treatment.

Much pain is often experienced in perforating ulcers and in sinuses leading to dead bone, especially by patients who are other wise anæsthetic. Free incision down to the bone gives great relief in these cases. The effect of this treatment is appreciated by the patients, who eagerly beg to be operated on. There is also no doubt that early incision in such cases does much to prevent the gangrene which is so common in leprosy. When this gangrene has actually set in, amputa-

⁽²³⁾ *Lancet*, 1886.

⁽²⁴⁾ *Edinburgh Medical Journal*, 1884-85.

⁽²⁵⁾ *Indian Medical Gazette*, 1888.

⁽²⁶⁾ *British Medical Journal*, 1888.

tion high up will often save life, and the patient will regain flesh and strength in a remarkable manner.

Dyspnœa, due to invasion of the larynx by tubercles, is not uncommon in leprosy, and sometimes necessitates tracheotomy. Life may be greatly prolonged after this operation. Dr. P. S. Abraham,²⁷ after a visit to the Norwegian Leper Asylums in 1888, writes: "I was shown numerous cases of amputations and tracheotomies. One patient at Bergen had worn a tube for three years, another for seven years, another at Trondhjem for ten years, and a great many others in all the asylums for shorter periods. In one case at Trondhjem the larynx subsequently became functionally useful, and the tube was discarded and the opening closed."

Lastly, reference must be made to the ophthalmic complications so common in leprosy. Leloir²⁸ noted during his visit to Norway that of sixty-four lepers at Molde, forty-one had ophthalmic lesions, in thirty-seven both eyes were affected, while six were absolutely blind.

The two commonest affections of the eye in leprosy are invasion of the cornea by tubercles, and paralytic ectropion, the former occurring in the tuberculated, the latter in the anæsthetic form of the disease.

To arrest the progress of tubercles across the cornea various methods of treatment have been adopted. Kaurin has attained considerable success by the performance of keratotomy. Danielssen and Hansen have produced similar results by cauterizing the conjunctiva or cornea round the tubercle. In the Trinidad Asylum ligation of the vessels supplying the tubercle has arrested its growth for a time. Iridectomy will in some cases temporarily avert total blindness, though it cannot affect the progress of the disease. It must, however, be undertaken before the iris becomes involved

⁽²⁷⁾ Epidemiological Society's Transactions, Vol. VIII, page 135.

⁽²⁸⁾ Traité Pratique et Théorique de la Lèpre, page 316.

in the leprosy growth, otherwise it will be found impossible to excise sufficient to produce any appreciable effect.

For paralytic ectropion Kaurin practises tarsoraphy with good results. Epiphora is greatly reduced, and closure of the lids is effected.

Enough has now been said of the surgical treatment of leprosy to show that in any well-organised asylum no operation need be refused. Indeed the leper may be treated like an ordinary surgical patient in a general hospital.

This chapter will be concluded by the following table showing the medical and surgical treatment adopted in various Indian stations with the results obtained:—

*Results of Treatment of Leprosy in India.**

Station or Asylum.	Medical Officer.	Treatment.	Result.
Assam.			
Sylhet . . .	Dr. T. O. Partridge.	Gurjun oil and Lime-water. Liquor arsenicalis.	Not satisfactory.
Bengal.			
Balasore . .	Assistant Surgeon Moti Lal Mukerjee.	Gurjun and Carbolic oils.	Slight relief, but no cure.
Backergunge .	Surgeon G. Jameson.	Gurjun oil internally and externally; Ichthyol and Resorcin internally and externally.	Anæsthetic patches disappear and ulcers heal.
Bankoora . .	Dr. Umes Chunder Mukerjee.	Gurjun and Neem oils; also Gurjun oil and Lime-water.	Temporary relief.
Blagapur . .	Surgeon-Major W. Beatson.	Gurjun oil locally, Chaulmoogra oil internally and externally.	No permanent benefit.
Beerbhoom .	Dr. W. Forsyth .	Arsenic . . .	No effect.

* Several stations have been omitted, as the answers to the questions sent out by the Commissioner arrived too late for the press.

Results of Treatment of Leprosy in India—continued.

Station or Asylum.	Medical Officer.	Treatment.	Result.
Bengal—contd.			
Burdwan	Surgeon-Major G. Price.	Ichthyol and Resorcin	Improvement, but no absolute cure.
Calcutta	Dr. T. Nath Bose.	Chaulmoogra oil internally and externally; Madar powder, Neem oil, Salol and Dr. Unna's treatment.	No permanent benefit.
Chittagong	Surgeon-Major W. Flood Murray.	Gurjun oil	Beneficial.
Chittagong Hill Tracts.	Assistant Surgeon Kali Nath Banerjee.	Chaulmoogra oil internally and externally; Cod-liver oil, Iron, Iodine and Arsenic with local antiseptic treatment of ulcers.	Improvement in several cases.
Cooch Behar	Dr. J. L. Hendley.	Gurjun, Carbolic and Chaulmoogra oils.	Tubercles appear to fade away; and relief to ulcers.
Dacca	Surgeon-Major F. C. Nicholson.	Gurjun, Chaulmoogra and Carbolic oils.	Temporary improvement.
Eastern Bengal State Railway.	Dr. C. C. Bose.	Gurjun and Chaulmoogra oils.	Progress of the disease arrested and sensibility restored.
Gya	Surgeon-Major F. D. Murray.	Gurjun oil and Arsenic.	Some improvement, but never cure.
Haughly	Surgeon-Major B. Gupta.	Gurjun oil.	Improvement in general health and healing of ulcers.
Lohardugga (Lepet Asylum).	Reverend F. Hahn	Liquor arsenicalis, Chaulmoogra and Gurjun oils.	The ulceration stops, the sores heal up, and general condition of patient improves.

Results of Treatment of Leprosy in India—continued.

Station or Asylum.	Medical Officer.	Treatment.	Result.
Bengal—contd.			
Malda	Apothecary J. Kelly.	Gurjun oil.	No permanent relief.
Midnapore	Surgeon-Major R. L. Dutt.	Arsenic Potassium iodide where there is constitutional syphilis; Neem or Gurjun oils with Lime-water.	The eruptions, tubercles and ulcerations disappear in most cases and in some great improvement, but not a radical cure.
Monghyr	Assistant Surgeon Upendra Nath Sen.	Iron, Strychnia, Quinine, Cod-liver and Neem oils internally; Perchloride of mercury lotion (1-1000), Carbolic oil (1-40), Gurjun and Neem oils externally.	Improvement of general health, healing of ulcers and in some cases the disease checked and the symptoms ameliorated.
Mozufferpore	Surgeon F. S. Peck	Hydrochloric acid internally; Ichthyol Resorcin, Pyrogallie acid, Chrysarobin, Salicylic acid, and Neem oil externally.	No perceptible improvement.
Mymensingh	Surgeon-Major D. Basu.	Gurjun and Chaulmoogra oils with Lime-water internally; and Gurjun and Chaulmoogra oils externally.	Much improvement, but no cure.
Patna	Surgeon-Major E. G. Russell.	Aristol externally. Gurjun, Chaulmoogra and Cashew-nut oils and Liquor arsenicalis.	Amelioration in many cases.
Pooree	Surgeon E. H. Brown.	Chaulmoogra and Gurjun oils; Unna's treatment (Resorcin and Ichthyol).	Temporary relief.

Results of Treatment of Leprosy in India—continued.

Station or Asylum.	Medical Officer.	Treatment.	Result.
Bengal—contd.			
Parulid . . .	Surgeon-Major H. W. Hill.	Pyrogallie acid ointment; Ichthyol pill and ointment; Resorcin ointment; Aristol, Iodoform dressings, Carbolic oil.	Ulceration is arrested, but it breaks out again, if the individual partakes of fish diet.
Sealdah (Campbell Medical School and Hospital).	Surgeon-Major R. Cobb.	Arsenic, Potassium iodide and Gurjun oil internally; Cashewnut, Chaulmoogra and Gurjun oils and Carbolic acid externally.	Temporary and local improvement.
Shahabad . . .	Assistant Surgeon Nitro Gopal Mittra.	Gurjun oils internally and externally. Fowler's solution, Denovan's solution, Iron preparations, Resorcin and Ichthyol.	Little or no effect.
Sonthal Pergunnahs.	Assistant Surgeon Gopal Chunder Dey.	Gurjun and Chaulmoogra oils internally and externally; also Arsenic and Potassium iodide.	No permanent relief.
Tipperah . . .	Surgeon R. R. H. Whitwell.	Gurjun oil internally and externally.	None.
24-Pergunnahs . . .	Surgeon-Major J. F. P. McConnell.	Potassium iodide or Arsenic, or both internally, and Gurjun ointment externally.	Marked, but temporary amelioration of symptoms.
Bombay.			
Ahmedabad . . .	Surgeon-Major M. L. Bartholomew.	Ichthyol, Aristol and Resorcin; also Chaulmoogra and Gurjun oils.	No permanent benefit.
Belgaum . . .	Surgeon-Major J. P. Greany.	Chaulmoogra and Gurjun oils, also Urea's treatment.	Slight relief.
Breach . . .	Surgeon K. H. Mistri.	Chaulmoogra and Gurjun oils, both internally and externally.	Effects not noted.

Results of Treatment of Leprosy in India—continued.

Station or Asylum.	Medical Officer.	Treatment.	Result.
Bombay—contd.			
Dharwar . . .	Surgeon-Major W. McConaghy.	Chaulmoogra oil, both internally and externally, Cashewnut oil externally, Arsenic, also Gurjun oil.	No permanent relief.
Dhulia . . .	Surgeon-Major K. A. Dalal.	Gurjun oil, both internally and externally.	No effect.
Hyderabad (Sind)	Surgeon-Major J. F. Keith.	Chaulmoogra oil.	No effect.
Jamsetjee Jeejeebhoy Hospital.	Surgeon-Major W. K. Hatch.	Chaulmoogra and Gurjun oils.	Beneficial in anæsthetic form.
Kurrachee . . .	Surgeon-Major J. McCleghry.	Gurjun oil.	None.
Mahabaleshwar . . .	Surgeon H. P. Dinmock.	Arsenic.	Marked improvement.
Matoonga . . .	Dr. N. H. Choksy	Chaulmoogra and Gurjun oil.	Too early yet to obtain any appreciable results.
Poona . . .	Surgeon W. H. Burke.	Chaulmoogra and Gurjun oils, internally and externally, Antiseptic dressings to ulcers.	Improvement in general health and temporary relief to ulcers.
Rajkot (Kathiawar Agency).	Surgeon-Major F. C. Barker.	Tonics, Alteratives, Chaulmoogra and Gurjun oils internally; Gurjun oil and other ointments to the ulcers.	No specific effect on the disease.
Ratnagiri . . .	Surgeon-Major H. McCalman.	Gurjun, Chaulmoogra and Cashewnut oils, recently Resorcin, Ichthyol, Fish oil and Pyrogallie acid. Local antiseptic and stimulating dressings to ulcers, also Carbolic oil, Iodoform, Eucalyptus, Iron, Arsenic and Cod-liver oil.	No specific effect.

Results of Treatment of Leprosy in India—continued.

Station or Asylum.	Medical Officer.	Treatment.	Result.
Bombay—concl'd.			
Sawantwadi	Dr. D. G. Dalgado	Arsenic pills internally, Chaulmoogra and Gurjun oils externally.	Invariably improvement in general health and partial subsidence of the disease in many cases, but no cure.
Thana	Surgeon-Major K. R. Kirtikar.	Chaulmoogra, Gurjun and Kowli oils, internally and externally, Hydrocotyle Asiatica, Aristol, Tonics, Massage.	In many cases diminution of size of tubercles, and some return of sensation to anesthetic patches. No absolute cure.
Yerrowda Prison	Surgeon-Major S. M. Salaman.	Alteratives, Tonics. Cooling lotions to the face, Chaulmoogra and Gurjun oils, internally and externally.	No effect.
Central Provinces.			
Damoh	Surgeon A. C. Deare.	Gurjun oil internally and externally; Carbolic oil.	Temporary benefit.
Narsingpur	Brigade-Surgeon P. Cullen.	Chaulmoogra and Gurjun oils; Quinine and Iron, Antiseptic dressing to ulcers.	Benefit in a small number of cases.
Chhindwara	Surgeon W. L. Price.	Chaulmoogra oil; Iron and arsenic.	Slight improvement.
Sambalpur	Assistant Apothecary D. O'Connell Murphy.	Internally—Tonics and Alteratives, Liquor arsenicalis, Bitter Infusions, Chaulmoogra oil and Lime-water. Externally—Before ulcerative stage Chaulmoogra oil, after Carbolic ointment and oil and Antiseptic dressings.	Some of the ulcers healed, but no visible effects were noticed on the constitution.

Results of Treatment of Leprosy in India—continued.

Station or Asylum.	Medical Officer.	Treatment.	Result.
Madras.			
Anantapur.	Assistant Surgeon B. F. Gonsalves.	Arsenic, Chaulmoogra and Gurjun oil, Potassium iodide, Tonics.	Temporary benefit.
Calicut	Surgeon-Major L. Beech.	Gurjun and Carbolic oils for ulcers.	Temporary relief.
Chingleput	Surgeon S. C. Sarkis.	Gurjun oil and Tonics.	Relief, but no permanent cure.
Chittoor	Assistant Surgeon A. J. Hesterlow.	Gurjun oil internally and externally.	It ameliorates the symptoms, but no cure has been noticed.
Coimbatore	Surgeon-Major H. J. Hazlett.	Gurjun oil	It certainly has a curative effect, but probably this is not permanent.
Coonoor	Surgeon-Major F. C. Smith.	Gurjun and Chaulmoogra oils.	Unknown.
Cuddapah	Surgeon A. T. O'Hara.	Gurjun and Carbolic oils.	Only temporary relief after continued treatment.
Kistna	Assistant Surgeon C. Munisawmy.	Gurjun and Chaulmoogra oils, Arsenic, Cod-liver oil, Blood tonics.	Symptoms abate, but no single case cured.
Kurnool	Brigade-Surgeon L. C. Nanney.	Gurjun oil	Prolonged treatment with good food and hygiene; if it does not cure, it at any rate checks progress of disease.
Madras	Surgeon-Major H. D. Cook.	Chaulmoogra oil internally and externally.	No effect whatever on the disease.
Madura	Surgeon W. B. Browning.	Gurjun and Chaulmoogra oils.	Any good results due to increased cleanliness and improvement in nutrition under better hygiene and diet.

Results of Treatment of Leprosy in India—continued.

Station or Asylum.	Medical Officer.	Treatment.	Result.
Madras—contd.			
Nellore . . .	Surgeon-Major G. L. Walker.	Internally—A mixture of Potassium iodide, Liquor arsenicalis and Liquor strychnine, also Gurjun and Chaulmoogra oils externally. For ulcers Carbolic oil dressings, Iodoform and Mercury ointments.	Under treatment and good food disease markedly ameliorated, general health much improved, the ulcers heal, the raised macular patches became much less prominent, but no case was cured.
Pallipatt . . .	Surgeon-Major D. Elcum.	Gurjun, Chaulmoogra, and Carbolic oils. Fumigation with Carbolic acid.	State of ulcers improved slightly. No other result.
Tanjore . . .	Surgeon-Major A. F. Nailer.	Chaulmoogra oil.	Improvement in general health.
Tellichery . . .	Assistant Surgeon C. A. Lafrenais.	Gurjun and Chaulmoogra oils.	Very little benefit.
Trichinopoly . . .	Surgeon-Major H. Hyde.	Chaulmoogra oil internally and Gurjun oil externally.	Progress of disease retarded in some cases.
Vellore . . .	Surgeon-Major T. J. H. Wilkins.	Sodium salicylate and Arsenic internally with Chrysophanic acid externally, Chaulmoogra oil.	In two cases disease appeared to be almost cured, but in others the symptoms did not seem to be relieved.
North-Western Provinces and Oudh.			
Agra . . .	Surgeon-Major A. Wilcocks.	Gurjun oil, Aristol, Resorcin and Ichthyol.	More or less improvement but nothing approaching a cure.
Aligarh . . .	Surgeon-Major W. H. Cadge.	Chaulmoogra oil.	Slight relief.
Allahabad . . .	Surgeon-Major J. McConaghey.	Ichthyol and Resorcin, Chaulmoogra oil.	Nothing beyond what might be expected after good diet and cleanliness.
Almora . . .	Reverend G. H. Bulloch.	Gurjun and Chaulmoogra oils, Carbolic acid, Potassium iodide, Resorcin, and Ichthyol.	Ulcers were healed, but only for a time.

Results of Treatment of Leprosy in India—continued.

Station or Asylum.	Medical Officer.	Treatment.	Result.
North-Western Provinces and Oudh—contd.			
Bahraich . . .	Surgeon W. Deane	Chaulmoogra and Gurjun oils, Ichthyol, Resorcin, and Aristol.	Chaulmoogra oil kept the sores healed, but Gurjun oil appeared of no use. No cure has been observed.
Ballia . . .	Assistant Surgeon Sheoraj Misra.	Gurjun and Chaulmoogra oils internally and externally.	Relief, but no complete cure.
Banda . . .	Surgeon-Major J. Moran.	Tonics, Arsenic, and Cod-liver oil internally and dilute Citric ointment locally.	No satisfactory result.
Bareilly . . .	Surgeon-Major J. Anderson.	Ichthyol internally and Aristol externally (since October 1890).	Ulcerations rapidly heal, but no change for the better in the constitution has been observed.
Benares . . .	Brigade-Surgeon W. R. Hooper.	Gurjun oil.	Only temporary benefit.
Budaun . . .	Surgeon-Major J. C. C. Smith.	Chaulmoogra and Gurjun oils, Resorcin, Ichthyol, and Arsenic.	Ulceration in several cases cured and anaesthesia often relieved, but the thickening of skin and other symptoms do not yield to treatment.
Dehra Dun . . .	Surgeon-Major G. G. MacLaren.	Chaulmoogra oil, Aristol, Gurjun oil, Sodium phosphate, Resorcin, and Ichthyol.	Chaulmoogra oil gave general relief. Aristol in many instances has proved a useful and rapid healing agent in external ulceration. No lasting good effect from Gurjun oil, Phosphate of soda, Resorcin, and Ichthyol.
Etawah . . .	Surgeon-Major E. S. Brandt.	Gurjun oil.	Results negative.
Fyzabad . . .	Surgeon J. Sykes.	Arsenic and juice of Madar internally, Gurjun oil internally and externally, Carbolic oil to ulcers.	Temporary relief.

Results of Treatment of Leprosy in India—continued.

Station or Asylum.	Medical Officer.	Treatment.	Result.
North-Western Provinces and Oudh—contd.			
Ghaziपुर . .	Surgeon J. F. MacLaren.	Arsenic internally, Chaulmoogra and Gurjun oils internally and externally.	In primary stage tubercles decreased after the use of Gurjun oil, but in advanced stages where there was ulceration, no benefit was observed. Ichthyol and Resorcin had no effect.
Gonda . .	Surgeon-Major C. Cameron.	Gurjun oil . .	Temporary benefit, but no cure.
Hardoi . .	Dr. G. D. McReddie	Arsenic, Gurjun oil, Carbolic acid. Chrysarobin externally and Ichthyol internally are now being tried on a prisoner.	No cure. Carbolic acid arrests ulcerations only. Tubercular appearance of skin decreased.
Jaunpur . .	Surgeon-Major F. C. Chatterji.	Gurjun and Chaulmoogra oils, Liquor arsenicalis, Tonics, Nerve-stretching.	General improvement, but no cure.
Jhansi . .	Surgeon C. P. Lukis.	Chaulmoogra oil, Tonics, Nerve-stretching.	None. Nerve-stretching for anæsthetic leprosy is a complete failure.
Kheri . .	Surgeon-Major M. D. Moriarty.	Gurjun and Chaulmoogra oils, Arsenic, Iron.	Slight improvement.
Lalitpur . .	Dr. G. T. Leopold	Gurjun ointment and Chaulmoogra oil.	Gurjun ointment seems to check the disease a little.
Mainpuri . .	Surgeon-Major G. M. Nixon.	Chaulmoogra and Gurjun oils, Donovan's solution, Tonics.	Marked improvement in many cases, but no complete cure.
Meerut . .	Brigade-Surgeon W. Moir.	Carbolic acid internally and externally with Arsenic and Donovan's solution. Gurjun oil more recently.	Any tonic treatment produces some temporary improvement, but there is no permanent cure. No success.

Results of Treatment of Leprosy in India—continued.

Station or Asylum.	Medical Officer.	Treatment.	Result.
North-Western Provinces and Oudh—contd.			
Naini Gaol . .	Surgeon-Major G. C. Hall.	Arsenic, Mercury, Strychnia, Phosphorus, Chaulmoogra and Gurjun oils, Ichthyol, and Resorcin.	No effect whatever from any special treatment.
Parbhaggarh . .	Senior Apothecary S. Bond.	Gurjun and Chaulmoogra oils, Liquor arsenicalis, Mercury, Potassium iodide, Tonics.	Considerable relief after prolonged treatment and cure.
Roorkee . .	Surgeon-Major J. Young.	Gurjun oil . .	No curative effect.
Sitapur . .	Surgeon-Major D. F. Barry.	Nerve-stretching . .	Improvement in the area supplied by the nerve operated on. General progress of the disease unaffected.
Unao . .	Senior Apothecary F. W. Saunders.	Arsenic, Chaulmoogra oil, Tar ointment.	Ulcers begin to heal and the symptoms are palliated.
Punjab.			
Baba Lakhn (Siakot) . .	Assistant Surgeon Mehta Duni Chand.	Liquor arsenicalis internally, Carbolic oil for ulcers, Gurjun oil both internally and externally, Tonics and Stomachics.	Symptoms relieved, but no case has been cured.
Hoshiarpur . .	Dr. N. P. Dutta . .	Gurjun oil . .	Temporary relief. Ulcers begin to heal more quickly than before the use of the oil.
Jullundur . .	Surgeon-Major M. O. Dwyer.	No specific remedies. Carbolic oil and various ointments for ulcers.	No effect.
Ludhiana . .	Assistant Surgeon Bhagwan Das.	Tonics, Chaulmoogra and Gurjun oils.	Result not known.

Results of Treatment of Leprosy in India—concluded.

Station or Asylum.	Medical Officer.	Treatment.	Result.
Punjab—contd. Peshawar .	Surgeon H. Hendley	Gurjun oil internally and externally, Chaulmoogra oil, Arsenic, Calcium sulphite, Tonics, Arsenic and Potassium iodide internally, Sulphur and Carbolic Acid externally.	Little or no effect.
Shahpur .	Assistant Apothecary C. J. Maher.	Gurjun oil and ointment, Chaulmoogra oil and earth baths, Electricity.	No result.
Subathu .	Reverend J. W. J. Wylie.	Tincture of Iodine, Carbolic acid.	Pain temporarily relieved. No cure.
Tarn Taran .	Assistant Surgeon Gulam Mustafa.	Chaulmoogra and Gurjun oils, Castanet oil externally, Liquor arsenicalis, Potassium iodide, Iodoform, Carbolic acid, Liniments, Resorcin, and Ichthyol ointment externally, Ichthyol internally.	No marked effect. No diminution of anesthesia of the benumbed part of the body. No change in the appearance of tubercles. When using these remedies, however, the skin remains soft and supple and patients become a little stronger. No case is ever cured.
Umballa .	Surgeon G. W. P. Denny.	Chaulmoogra and Gurjun oils, Ichthyol, Resorcin, and Aristol.	Diminution of tubercles. Cessation of several symptoms.
NATIVE STATES. Mysore.			
Bangalore .	Brigade-Surgeon T. J. McGann.	Gurjun oil, Carbolic acid, Iodine, Hoangnan, Ichthyol internally and Resorcin externally.	Temporary improvement, but in no case has there been a cure.
Punjab. Kashmir .	Dr. A. Mitra.	Nerve-stretching is largely practised, Gurjun oil lately, Creolin for leprosy ulcers.	Nerve-stretching checks the progress of disease in its early stage in a large number of cases.

APPENDIX I.

SURGEON-MAJOR H. D. COOK'S REPORT ON SALOL IN THE TREATMENT OF LEPROSY.

OFFICE OF THE SUPERINTENDENT, GOVERNMENT LEPROSY HOSPITAL,

Madras, 31st August 1891.

From—SURGEON-MAJOR H. D. COOK, M.B., Supdt., Government Leprosy Hospital,

To—A. A. KANTHACK, Esq., F.R.C.S., Member of the Leprosy Commission.

I have the honour to inform you that, in compliance with your request, I began the treatment of twelve patients, selected for the purpose, with Salol on the 26th ultimo and continued it up to date (a period of five weeks), strictly adhering to your instructions.

According to directions I administered 3 doses, a dose after each meal daily, beginning with 20 grains and increasing it to 30 grains. A careful diagnosis was made of each case, and duly registered prior to the treatment, and critically scrutinized from time to time during the treatment, and any perceptible reaction duly noted.

So far as can be seen from observation of the twelve cases under treatment Salol has a mitigating effect, ulcers heal and tubercles ulcerate and subside, fresh tubercles crop up and burst, subside, and are followed by another lot, and so on. I am of opinion that sufficient time has not been allowed to enable me to form a correct estimate of the value of salol as a therapeutic agent in leprosy, and that a steady, unremitted course of three months' treatment with it would at least be required. So I will keep up these cases and send you the continuation of the treatment, even after you go home, if you should so wish.

DETAILED REPORT OF TWELVE CASES OF LEPROSY TREATED WITH SALOL.

CASE I.—Hindu, male, aged 25 years; suffering from MIXED LEPROSY for last four years.

Present condition.—Borders and lobes of both ears tuberculated; minute tubercles on the nose and chin; forehead and cheeks slightly thickened. Minute tubercles on the little fingers of both hands, the remaining fingers slightly thickened. Discoloration of the skin of

the trunk and both thighs. Shins of both legs are covered with dark patches and shiny; feet are covered with scaly patches. Loss of sensation in little finger of right hand, and from knee downward to tips of toes in both lower extremities.

July 26th.—Salol, gr. xx, three times a day.

August 3rd.—Gaining sensation in the little finger of right hand.

August 10th.—Minute tubercles on the little fingers of both hands ulcerating, discharging freely, and then subsiding. *There is much improvement*, and patient is gaining more sensation in the little fingers of right hand.

August 10th.—Salol, gr. xxx, three times a day.

August 16th.—No change.

August 19th.—Fresh minute tubercles have appeared on both hands.

August 27th.—Some of the tubercles mentioned above have ulcerated and are healing up.

Treatment still continued

CASE II.—Hindu, male, aged 26 years; suffering from TUBERCULAR LEPROSY for last ten years.

Present condition.—Minute tubercles on the lobes of both ears, nose and chin. Skin of face slightly thickened. Skin of the body discoloured, and covered with dry, scaly patches of a lighter colour than the natural skin; and also psoriasis. Discoloration of the skin of both upper extremities; both legs are covered with brown patches peculiarly shiny; toes are thickened, and there is an ulcer on the inner side of the right great toe. No loss of sensation anywhere. Both feet are swollen.

July 26th.—Salol, gr. xx, three times a day.

August 3rd.—Complains of severe pain over the abdomen and burning sensation on the soles of the feet after taking the medicine.

Treatment continued.

August 10th.—No improvement.

Salol, gr. xxx, three times a day.

August 16th.—No improvement.

Treatment continued.

August 19th.—Pain over the abdomen, and burning on the soles of the feet is worse; ulcer broke out on the dorsum of right foot.

August 27th.—No improvement.

CASE III.—Hindu, male, aged 32 years; suffering from MIXED LEPROSY for last nine years.

Present condition.—The skin of the whole face, chin, nose, and ears thickened and tuberculated; skin of trunk and extremities discoloured and thickened by a mass of minute inter-current tubercles. Fingers and feet slightly thickened; brown shiny patches on both shins; toes much thickened, nails wasting away. Slight anæsthesia in hands and legs. This is a more macular form of the disease. Slight loss of sensation on the soles of both feet.

July 26th.—Salol, gr. xx, three times a day.

August 3rd.—Several tubercles on the trunk and extremities have ulcerated and subsided; gaining sensation in the tubercles of the face, being very painful to the touch.

Treatment continued.

August 10th.—More tubercles on the trunk and extremities have subsided. He is gaining sensation in hands and legs. Tubercles on the face somewhat depressed and not so much elevated, but very painful. *He states he is improving greatly.*

Salol, gr. xxx, three times a day.

August 18th.—Tubercles on the face look somewhat depressed and are painful, and those of the forearms have ulcerated and are subsiding.

Treatment continued.

CASE IV.—Pariah, male, aged 36 years; suffering from ANÆSTHETIC LEPROSY from infancy.

Present condition.—Copper coloured anæsthetic patches on both cheeks and on the neck. Front and back of the trunk are covered with similar circular patches, much lighter than the natural skin, attended by loss of sensation. Similar patches on both upper arms; fingers of both hands exhibiting signs of contraction; little fingers of both hands are already slightly contracted. The buttocks and both lower extremities are covered with similar kind of patches, attended by loss of sensation. Toes of both feet are swollen, and there is a characteristic deep ulcer under the great toe of right foot.

Total anæsthesia in patches over the trunk and in both extremities.

July 7th.—Salol, gr. xx, three times a day.

August 3rd.—Gaining sensation in the fingers of both hands.

Treatment continued.

August 10th.—No change.

Salol, gr. xxx, three times a day.

August 18th.—Copper coloured anæsthetic patches all over body, several of them becoming darker and regaining sensation.

Treatment continued.

August 27th.—No further improvement.

Treatment continued.

CASE V.—Muhammadan, male, aged 20 years; suffering from TUBERCULAR LEPROSY for last four years.

Present condition.—Slight thickening of the skin of the nose and lobes of both ears; discoloration and desquamation of skin of both upper extremities; peculiar shiny appearance and dark patches on both the legs; both feet slightly swollen; toes of both feet present a peculiar shiny appearance. No loss of sensation anywhere.

July 26th.—Salol, gr. xx, three times a day.

August 3rd.—He complains of muscular pains all over the body which prevent him from sleeping during the night.

Salol, gr. xx, three times a day.

August 18th.—No improvement.

August 21st.—He absconded.

CASE VI.—Muhammadan, male, aged 20 years; suffering from MIXED LEPROSY for last ten years.

Present condition.—Minute tubercles on borders and lobes of both ears, discoloration and slight thickening of the skin of the face. Scaly dark patches on both forearms; fingers of both hands exhibiting signs of contraction, discoloration and dark patches in both lower extremities and a peculiar shiny appearance over shins of both legs; toes of both feet slightly swollen; nails wasting away. Discoloration of the skin of the trunk; anæsthesia in both upper and lower extremities.

July 26th.—Salol, gr. xx, three times a day.

August 3rd.—Improvement not to be seen.

Treatment continued.

August 10th.—Tubercles on the ears ulcerating.

Salol, gr. xx, three times a day.

August 18th.—Tubercles on the ears still sore; those of the forehead getting smaller in size.

Treatment continued.

CASE VII.—Hindu, male, aged 30 years; suffering from MIXED LEPROSY for last five years.

Present condition.—Tubercular thickening of the skin of the whole face, minute tubercles on both ears and nose; nose sunk in. Discoloration of the skin of the trunk, and the latter covered with psoriasis. Discoloration and slight thickening of the skin of the upper extremities, which are also covered with psoriasis. The little fingers of both hands are contracted; fingers swollen. Discoloration and slight thickening of the skin of both lower extremities; dark peculiar shiny patches on both shins, and tubercles around both ankles. Joints of both feet swollen, as well as toes; nails of toes wasting away. Loss of sensation over both the upper and lower extremities.

July 26th.—Salol, gr. xx, three times a day.

August 3rd.—Gaining sensation in both extremities; minute tubercles on both ears and nose absorbed; thickening of the skin remains.

August 10th.—Gaining sensation in the extremities; psoriasis is fading away; thickening of the skin of the face gradually going down; minute tubercles on the ears subsided, but thickening of the skin remains; skin is moist and not so dry as before.

He is much better.

Salol, gr. xxx, three times a day.

CASE VIII.—Hindu, male, aged 18 years; suffering from TUBERCULAR LEPROSY from infancy.

Present condition.—Tubercular thickening of the lobes and pinnae of both ears; cheeks, chin and nose also affected with a mass of tubercular thickening. Patches of tubercular thickening over both the front and back of the trunk. Minute tubercles on both forearms; and fingers of both hands swollen. Discoloration and slight thickening of the skin of both lower extremities; dark and peculiarly shiny appearance of both shins and feet. No loss of sensation anywhere.

July 26th.—Salol, gr. xx, three times a day.

August 3rd.—Several tubercles on the body and extremities have been absorbed; tubercular thickening of the face gradually going down.

August 10th.—Tubercles on the body and forearms have been greatly absorbed; tubercular thickening of the face is gradually going down.

Salol, gr. xxx, three times a day.

August 18th.—Fresh tubercles appearing on both upper extremities.

Treatment continued.

August 27th.—No further improvement.

CASE IX.—Hindu, female, aged 20 years; suffering from TUBERCULAR LEPROSY for last five years.

Present condition.—The whole of the face covered with minute tubercles; lobes of both ears and nose tuberculated. Both upper extremities covered with minute tubercles and skin slightly thickened. Front and back of the trunk also covered with similar tubercles; slight thickening of the skin of both lower extremities; peculiar dark shiny appearance of both shins. No loss of sensation anywhere.

July 26th.—Salol, gr. xx, three times a day.

August 3rd.—Tubercles on the face and upper extremities have a tendency to subside.

August 10th.—Many of the tubercles on the face, trunk, and extremities have subsided; dark patches on the shins are lighter.

Salol, gr. xxx, three times a day.

August 18th.—A mass of fresh tubercles has appeared over face and extremities.

Salol, gr. xxx, three times a day.

August 27th.—Some of the tubercles on the arms have subsided and fresh ones have appeared.

Treatment continued.

CASE X.—Native Christian, female, aged 14 years; suffering from MIXED LEPROSY for last two years.

Present condition.—Lobes and borders of both ears covered with tubercles; chin, nose, and whole of the face covered with minute tubercles. Slight thickening of the skin of both upper extremities; fourth and fifth fingers of right hand and little finger of left hand slightly contracted. Discoloration of the skin of the trunk and of lower extremities. Dark peculiar shiny patches on both shins; feet somewhat swollen. Left fourth toe and right second toe ulcerated. Complete anæsthesia of both lower extremities.

July 26th.—Salol, gr. xx, three times a day.

August 3rd.—Gaining sensation in both lower extremities.

Treatment continued.

August 10th.—Improvement very slight.

Treatment continued.

August 19th.—Itchy sensation all over the body.

Treatment continued.

August 27th.—She is getting good appetite; no further improvement.

CASE XI.—Hindu, female, aged 12 years; suffering from TUBERCULAR LEPROSY for last two years.

Present condition.—Cluster of tubercles on the nose, chin, and ears; skin of the whole face covered with minute tubercles. Both upper extremities covered with tubercles; a large tubercle situated on the dorsal aspect of right middle finger; fingers of both hands slightly swollen. Discoloration of the skin of the trunk. Dark shiny patches on both feet; toes thickened; nails gradually wasting away; ulcer on the under surface of right second toe. No loss of sensation anywhere.

July 26th.—Salol, gr. xx, three times a day.

August 3rd.—No change.

Treatment continued.

August 10th.—Tubercles on the face are slightly depressed.

Salol, gr. xxx, three times a day.

August 18th.—Complains of severe pain over abdomen; tongue sore; ulcer on the right foot getting worse.

August 27th.—No improvement. As she is suffering from dysentery the medicine is stopped.

CASE XII.—Native Christian, female, aged 15 years; suffering from TUBERCULAR LEPROSY for one year.

Present condition.—Skin of face somewhat shiny, and lobes of ears slightly thickened. A raised eruptive tubercular patch on the back, also on right upper arm, left forearm and left thigh. No loss of sensation over these maculæ. Peculiar shiny scaly appearance of both shins.

July 26th.—Salol, gr. xx, three times a day.

August 3rd.—No change.

Treatment continued.

August 8th.—Eruption has a tendency to subside; there is some improvement.

Salol, gr. xxx, three times a day.

August 8th.—Eruption is getting less and the thickening decreased.

Treatment continued.

August 27th—There is some itching over the eruptive patches.

Treatment continued.

ADDENDUM.

Since the return of the Commissioners to England Dr. Cook has continued the above treatment, but apparently without success, as may be gathered from his letter.

[GOVERNMENT LEPROSY HOSPITAL.]

Madras, 12th November 1891.

From—Surgeon-Major H. D. COOK, M.B., Supdt., Govt. Leprosy Hospital, Madras:

To—A. A. KENTHACK, Esq., F.R.C.S., St. John's College, Cambridge.

In continuation of my letter of 31st August 1891, I have to inform you that the salol treatment was continued up to 12th October 1891, thereby terminating the three months' treatment suggested by me—a trial sufficiently long to evince the virtue of Salol as a specific in leprosy. A few of the twelve cases under treatment derived some benefit, while the others improved in parts previously affected, but have broken out in parts formerly unaffected. Tubercles have subsided and already existing ulcers healed up, but after some time fresh tubercles and ulcers appeared. In addition patients complained of loss of appetite, lassitude and a disagreeable burning sensation in the stomach, eyes; in fact throughout the body. Considering that leprosy is a disease, requiring a steady persevering course of treatment, extending over a period of three months, if necessary a year, a specific that would recommend itself and combat successfully with the disease must necessarily possess properties of a progressively beneficial nature, so that its continued use would have no disagreeable counteraction; it must have tonic and alterative properties, and be such that its use could be continued for a long time without the least ill-effect. Salol in my estimation is of no therapeutic value in leprosy; in fact, I consider it a *decided failure*.

APPENDIX II.

EXPERIMENTS ON THE ACTION OF TUBERCULIN IN LEPROSY.

In connection with the treatment of leprosy mention must be made of a series of experiments with Koch's fluid which Surgeon-Major H. D. Cook of Madras kindly performed for the Commission. Twelve lepers were treated with tuberculin, obtained from Dr. A. Libbertz of Berlin. The observations were made, with but faint hope of achieving any therapeutic success, but rather to test the diagnostic value of the medium. For assuming tuberculin to be a specific in tubercular affection, it could *a priori* scarcely be considered probable that as such it could have been of any use in leprosy, even though one must allow a certain pathological resemblance between the two diseases. Besides, by the time the tuberculin reached India the majority of men expressed their doubt as to its efficacy even in tubercular disease. Various physicians, notably amongst them Dr. P. S. Abraham, Dr. Arning, Dr. Goldschmidt and Drs. Babés and Kalindero have tried the injection of Koch's fluid, but in no case has there been any permanent improvement, and hardly even any temporary benefit. Difference of opinion has been expressed as to value as a diagnostic means of tuberculin, that is, whether or no the injection of tuberculin is followed by a general and local reaction of a characteristic type. It was especially to test this point that the Commission requested Dr. Cook to try the effect of tuberculin on a number of lepers, carefully selected, free from any suspicion of tubercular disease, representing the various types of leprosy. No advanced cases were employed.

Dr. Cook's detailed report will be found appended. Here a short extract, with the conclusions based on the experiments, will be given. The patients were all male-Hindus, young adults suffering from leprosy in its less advanced stages. Four were affected with the anæsthetic form of the disease, four with tubercular leprosy, and the remaining four with the mixed form. Each patient was observed for a few days previous to the commencement of the injections and the day before, the temperature taken at morning, noon, and night. Then a minimal dose of tuberculin was injected (corrected), sometimes into an apparently healthy part, at other times into the diseased tissues. An interval of twenty-four hours always elapsed between two successive injections.

(1) Journal of the Leprosy Investigation Committee, No. 2, February 1890, page 110, of seq.

and to begin with, the dose was increased by '001cc until '005 was reached, when it was ventured to increase it by '002cc; '01 was the maximum dose ever given. The temperature was carefully observed every three hours, and whenever it rose above 102.5° the dose was not increased, but the same or a smaller dose given, until the temperature remained at or below 102.5° for some time. Injections were never continued, until the phenomena of reaction had abated.

No case was in any way, generally or locally, improved, although the treatment was continued for at least three weeks. One or two patients were decidedly the worse for the injections, being reduced in general health. In two instances the patients acknowledged a return of sensation into a primarily anæsthetic region, but this passed off quickly. In another case several ulcers healed up and remained so at the time the treatment was discontinued; in one instance tubercles in the face became less prominent. But with these exceptions the improvements were but slight and momentary, or altogether absent, so that the lepers lost all faith and patience. In four cases the use of tuberculin was followed by a general outbreak of psoriasis all over the body. These were of the mixed or tubercular type.

A general reaction was absent in two anæsthetic cases, one tubercular and one mixed case (or in four out of twelve cases). In seven cases,—one anæsthetic, three tubercular, and three mixed—it was well marked, while in one case it was but weak. The mere absence or presence of a general reaction, therefore, cannot be made the criterion between leprosy or tuberculosis, as was at one time assumed by Dr. Arning.² In Dr. Cook's patients tuberculosis was out of the question.

According to Professors V. Babés and Kalindero,³ the general reaction in the case of leprosy essentially differs from that established in tuberculosis. There is no doubt from a perusal of Dr. Cook's cases that, in accordance with these authors, a stronger dose is required to produce a febrile reaction in leprosy than in tuberculosis. Again the twelve cases confirm the statement of the same writers that in leprosy the general reaction, instead of in about six hours, does not ordinarily appear until twenty-four hours after injection. The cases offer, however, no evidence that the fever and concomitant symptoms last longer than in tuberculosis. But they may be said, on the whole, to confirm the other statement that after the first reaction a second appears on the following day, and at times even a third the day after (*cf.* Case XII). Local reactions failed in almost every case.

(²) Deutsche Med. Wochenschr, 1890, 50.

(³) Semaine Médicale. Jan. 26, 1891.

the ulcers, as a matter of fact, healing in only one instance. Amelioration of the general condition was not observed, but a general weakness was not uncommon.

The Commissioners, therefore, agree with Professors Babés and Kalindero that there are essential differences in the character of the reactions in the case of leprosy and tuberculosis, respectively, where these are typical; and that in a number of cases (as far as it is allowed to argue from so small a number of cases), Koch's remedy might distinguish whether an affection is leprosy or tubercular, provided it were proven that a typical reaction follows in all cases of tubercular, but never appears in healthy individuals. But they think that it can hardly be employed in the diagnosis of a suspicious trophoneurotic disease, seeing that of four anæsthetic cases no reaction occurred in two cases, while in a third case it was very weak. The most marked reactions occur in purely tubercular and mixed cases. The Commissioners also have no doubt that as far as leprosy is concerned, the remedy is of no therapeutic value, but, on the other hand, may not be altogether free from danger.

Table to show the Effect of Tuberculin in Leprosy.

Form of Disease.	Number of case.	Reaction.	Remarks.	Improvement.	Other changes.
ANÆSTHETIC	(1)	Very weak—practically nil	What little reaction there was appeared only after large doses were given	Nil	
	(2)	Practically nil		"	
	(3)	Weak		"	
	(4)	Well marked		"	
TUBERCULAR	(5)	Nil		Nil	
	(6)	Well marked		"	
	(7)	Ditto		"	Psoriasis.
	(8)	Ditto	when large doses given	"	Ditto.
MIXED	(9)	Ditto		"	Ditto.
	(10)	Practically nil		"	
	(11)	Well marked		"	
	(12)	Ditto	when large doses given	"	Psoriasis.

SURGEON-MAJOR H. D. COOK'S REPORT ON TUBERCULIN.

GOVERNMENT LEPER HOSPITAL,

Madras, June 1891.

From—Surgeon-Major H. D. COOK, M.B., Supdt., Govt. Leper Hospital,
Madras.

To—A. A. KANTHACK, Esq., F.R.C.S., New Club, Simla.

With reference to your letter dated Simla, 22nd April 1891, I have the honour to inform you that, in accordance with the directions contained therein, regarding the use of "Tuberculin," I began the treatment with it on twelve lepers selected for the purpose on the 27th ultimo and continued it till the 20th instant.

A minute diagnosis of each of these twelve cases being recorded (as per cases attached), they were inoculated with solutions of tuberculin carefully prepared by the local Chemical Examiner to the minimum strength of '001, and gradually increasing it at each successive injection performed every alternate day. When the temperature exceeded 102.5° , the minimum strength or one of less strength than that used at the previous operation, as the case required, was injected, till it reached '01cc.

From the careful observation of their temperatures with a clinical thermometer, every third hour, five times daily, and duly registered, the only effects noticeable were an increase of temperature, only temporarily attaining a maximum of 105° in three cases, accompanied with fever; and an average of 100.5° in others, while in three of these cases the temperature slightly exceeded the normal.

These symptoms, unaccompanied with the least mitigation of the disease, were the only results attained, and as the trial given was sufficiently long to exhibit any virtue, if there be, of the remedy, I have decided to discontinue the treatment. The patients who were under treatment got disheartened and one of them got very ill. These cases were typical of the various forms of leprosy, carefully selected, and not in an advanced stage, and I may remark here that every detail of the whole treatment was strictly observed from 27th May till 20th June 1891. The injections and the registration of temperature have been scrupulously carried out, so that I can safely say a fair trial has been given.

From the above remarks it may be seen that so far no mitigation of the symptoms has occurred, and therefore I think the "Tuberculin" for leprosy is a decided failure. It may be said that the injection should be continued for a long time, but the patients would not submit to a painful treatment, seeing no good result therefrom.

The Resident Apothecary, Mr. M. Nur Mahomed, has taken great pains with these cases throughout. Recording temperatures every three hours in twelve cases is of itself an irksome duty, and my thanks are due to him for so cheerfully assisting me with the experiments.

SURGEON-MAJOR COOK'S DETAILED REPORT OF TWELVE CASES OF LEPROSY TREATED WITH TUBERCULIN.

Case I.—Hindu, male, aged 39 years; suffering from ANÆSTHETIC LEPROSY for last five years.

Condition on June 3rd: A circular light patch immediately above the right eyebrow; similar patches on the sides of the lower jaw. A large light-coloured anæsthetic patch on posterior surface of the left elbow extending downwards. A large anæsthetic patch surrounding the right knee and both legs. A small characteristic ulcer on the right foot. Complete anæsthesia of both legs.

June 5th: 100cc. of tuberculin injected, and injections carried on until June 16th, when 100cc. was injected.

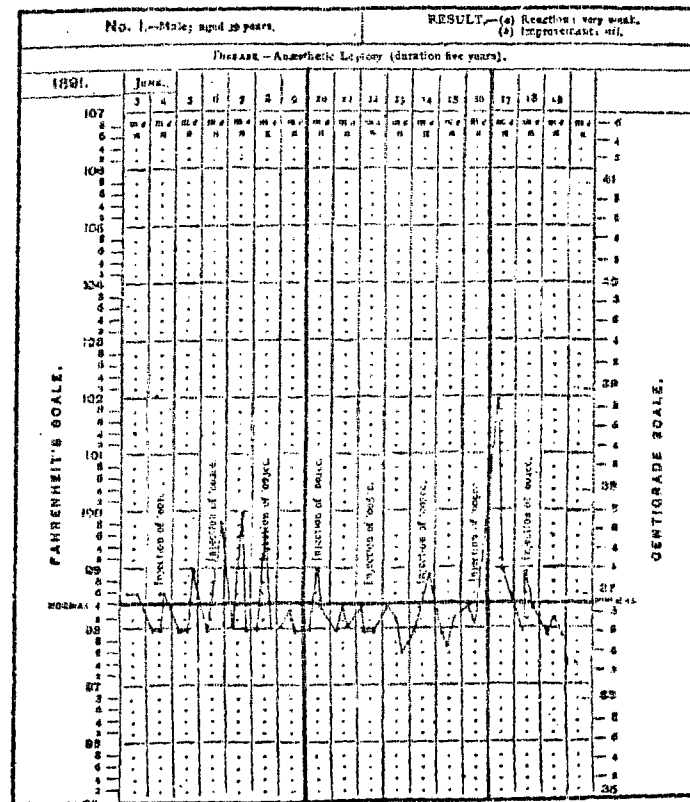
Practically NO REACTION: a slight rise of temperature at the commencement, and a marked rise when the largest dose was administered.

Improvement: nil.

Weight on June 3rd: 108lb.

" " 5th: 94lb.

" " 14th: 93lb.



Remarks.—Though the temperature was taken every three hours during the day, it has for the sake of simplicity, been registered morning, noon, and night in these charts.

Case II.—Hindu, male, aged 32 years; suffering from ANÆSTHETIC LEPROSY for last six months.

Condition on May 26th: Slightly raised patch on the forehead (macular) and face; a small patch on the right cheek; nose slightly thickened. Two small light patches a little above the right knee; a dark characteristic patch on dorsum of left foot.

Loss of co-ordination of movement of left leg; the foot falls when raised.

Slight anæsthesia of left leg and hyperæsthesia of face.

May 27th: 100cc. injected, and the usual injections continued.

Hardly any reaction, the temperature never rising above 101°, and then only after the maximum dose of 101 had been given for the second time.

Improvements: June 14th; decrease of anæsthesia of left foot, also a certain amount of increased power in that leg. Patches above right knee are paler.

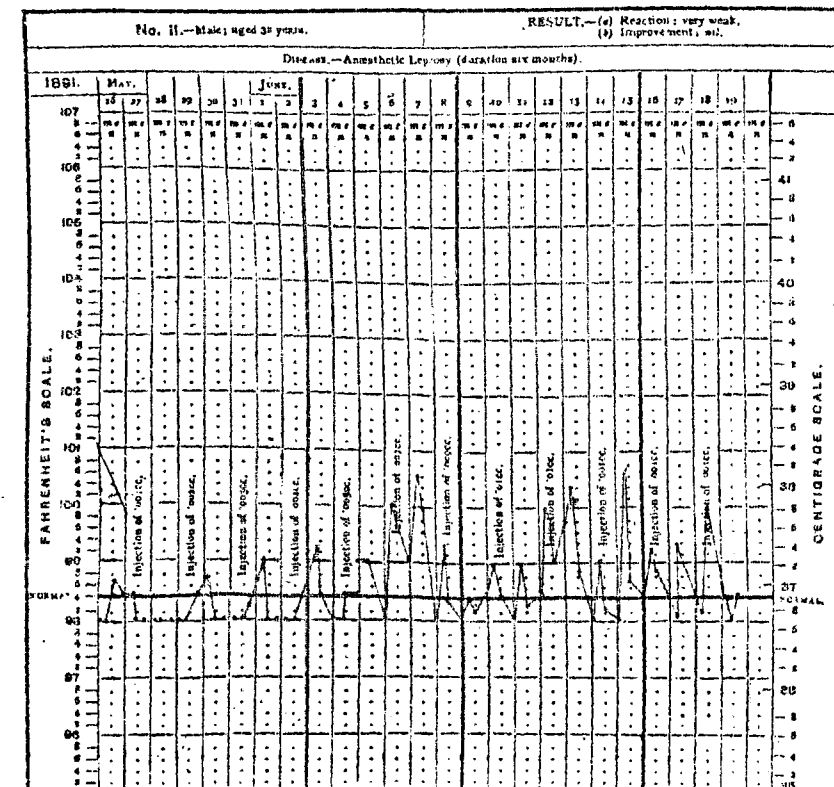
June 19th: anæsthesia of left foot as before, and loss of strength also as before.

Thus no improvement.

Weight on May 27th: 150½lb.

" " June 8th: 154lb.

" " 14th: 150½lb.



Case V.—Eurasian, male, aged 22 years; suffering from TUBERCULAR LEPROSY for ten years.

Condition on May 30th: Slight tubercular thickening of nose, lobes of both ears and chin, and tubercular thickening of the whole face. Dark patches over left shin. No anaesthesia.

May 31st: 1cc of tuberculin injected. The usual injections were carried on every other day, and the maximum dose given on June 14th.

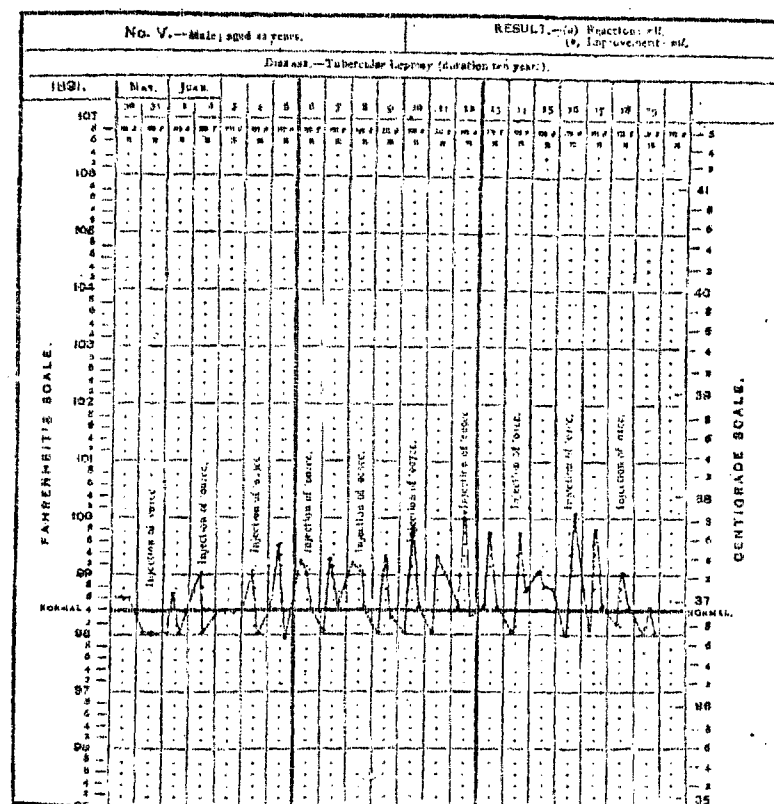
Reaction and rise of temperature practically nil.

Improvement: nil.

Weight on May 30th: 110lb.

" " June 8th: 108½lb.

" " " 14th: 108½lb.



Case VI.—Hindu, male, aged 20 years; suffering from TUBERCULAR LEPROSY; duration of disease: four years.

Condition on June 3rd: Tubercular thickening of lobes and pinnae of both ears, also of nose and lips; general thickening of face. Discoloration of skin of trunk and extremities. Epidermis scaly and desquamating. Fingers of both hands slightly thickened. Peculiar dark discolorations over both shins. Toes of feet thickened. No anaesthesia.

June 4th: 100cc. of tuberculin injected, and injections continued until 1000cc. was reached.

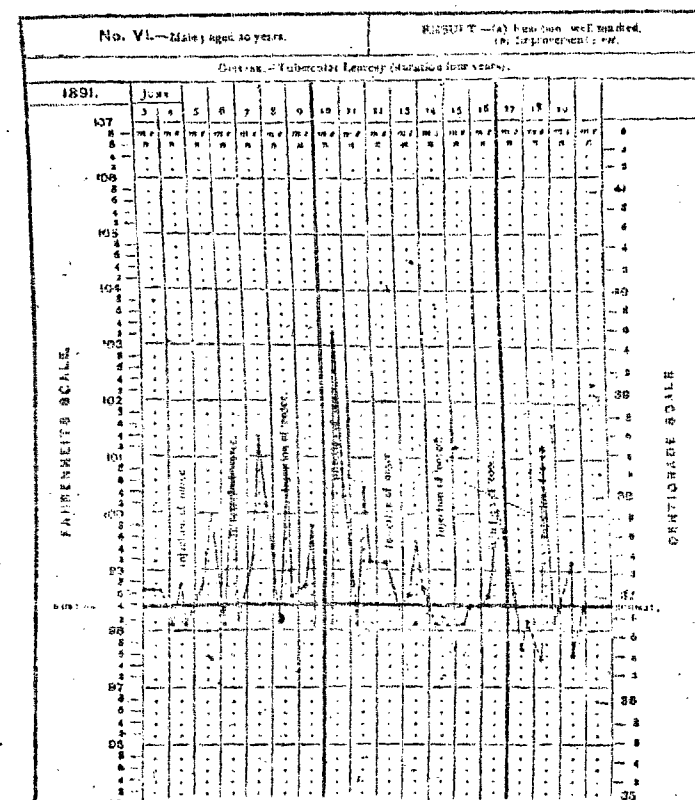
Reaction: Well marked.

Improvement: nil.

Weight on June 3rd: 110lb.

" " " 8th: 101lb.

" " " 14th: 104½lb.



Case VII.—Hindu, male, aged 28 years; suffering from TUBERCULAR LEPROSY for two and a half years.

Condition on June 1st: Tubercular thickening of lobes and pinnae of both ears; minute tubercles on the edge of the nose. Fingers of both hands thickened. Dark patches over both shins; toes of feet thickened and nails wasting. Psoriasis all over body. No anaesthesia.

June 2nd: '001cc. injected. When '003cc. was reached on June 6th the temperature rose to 102° 8', and to 103° the next day.

Reaction has been well marked throughout.

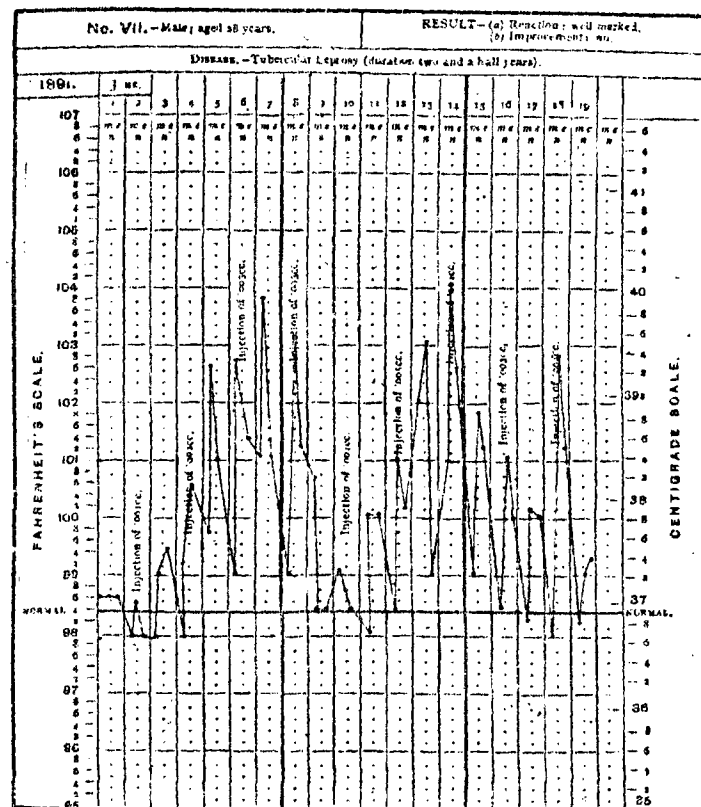
Improvement: nil.

June 19th: Psoriasis much aggravated (cf. Cases VIII, IX, and XII).

Weight on June 1st: 102lb.

" " " 8th: 102½lb.

" " " 14th: 99lb.



Case VIII.—Hindu, male, aged 22 years; suffering from TUBERCULAR LEPROSY; duration of disease: eight years.

Condition on May 28th: Minute tubercles on the chin, lips, nose, and lobes of both ears; slight thickening of whole face. Thickening and peculiar glossy appearance of fingers of both hands. Lower extremities discoloured and partially anaesthetic; toes of feet thickened; ulcer on great toe of left foot. Peculiar glossy appearance of skin over shin. Toes of both feet inclined to retract.

May 29th: '001cc. injected, and usual injections continued. When '005cc. was reached, signs of severe reaction appeared.

Reaction: Well marked with larger doses.

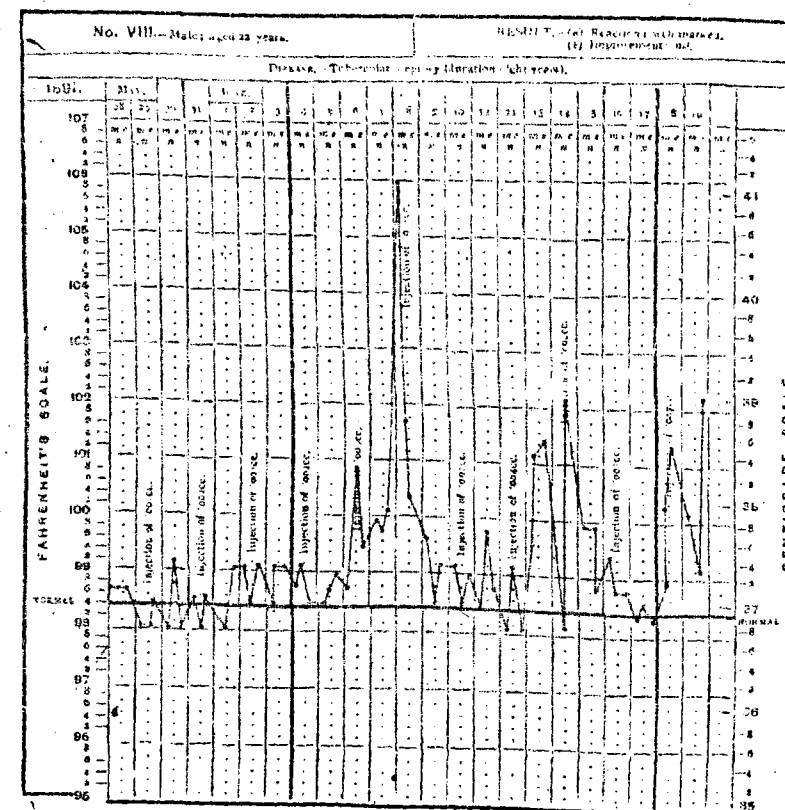
Improvement: At one time there was a decided diminution of the anaesthesia; but this passed off very quickly.

Psoriasis appeared all over the body (cf. Cases VII, IX, and XII).

Weight on May 28th: 119lb.

" " " 8th: 115lb.

" " " 14th: 113lb.



Case IX.—Hindu, male, aged 21 years; suffering from MIXED LEPROSY; duration of disease: seven years.

Condition on May 25th: Minute tubercles on chin, tips, nose; thickening of nose; tubercles on eyebrows and middle of forehead; general thickening of face; lobes of ears thickened and nodular. Fingers of both hands thickened and glossy. A big light patch a little above the left knee, which is more or less anæsthetic. Skin over shins glossy and discoloured. Both feet swollen; three inner toes of right foot, and the great and third toes of left foot ulcerated; nails atrophied. Total anæsthesia of left upper arm and left thigh.

May 27th: 100cc. injected. The dose was never increased beyond 100cc. on account of the rise of temperature.

June 12th: There seems to be some improvement: the ulcers on the toes are healed, the swelling of the feet subsided; the anæsthetic patch on left thigh is regaining sensation; the tubercles on the face are not so prominent.

June 19th: The anæsthetic patch has again lost its sensation and the feet are as swollen as before.

Psoriasis appeared all over the body (cf. Cases VII, VIII, and XII).

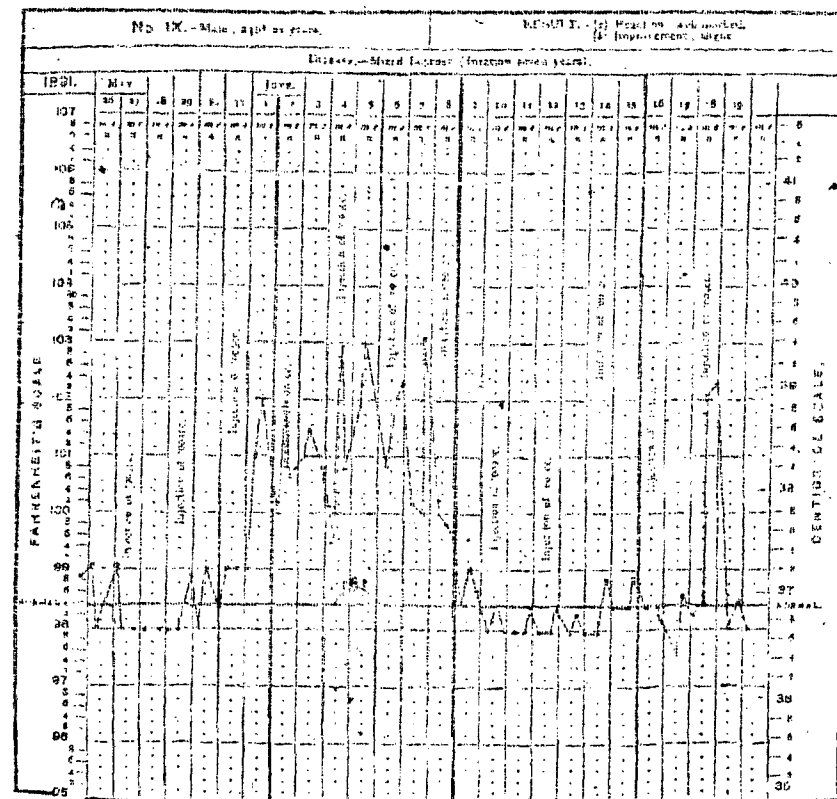
Reaction: Well marked.

Improvement: Slight and of passing nature.

Weight on May 26th: 94lb.

" " June 8th: 93lb.

" " " 14th: 83lb.



Case X.—Hindu, male, aged 25 years; suffering from MIXED LEPROSY; duration: seven years.

Condition on June 1st: Tubercular thickening of lobes and pinnae of both ears; nose very nodular; general thickening of face. Skin over whole of trunk discoloured. Mammary glands much enlarged. Raised anæsthetic patches on both lower extremities. Fingers thickened; left fingers retracted. Total anæsthesia of the extremities.

June 2nd: 100cc. injected. The usual injections administered every other day until 1007 was reached and the temperature rose to 101°.

June 10th: the maximum dose was given and temperature did not rise above 101°.

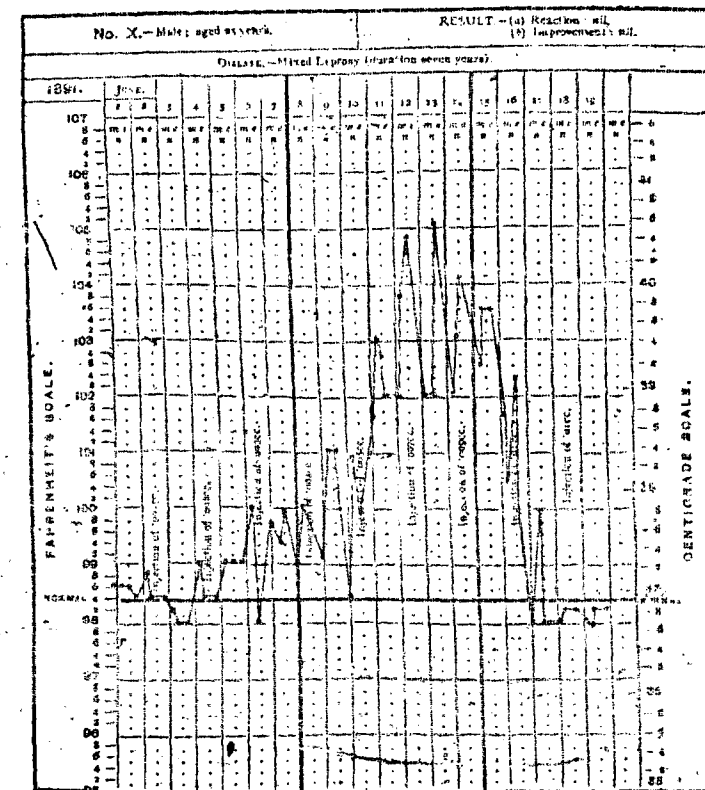
Reaction: practically nil.

Improvement: nil.

Weight on June 1st: 100lb.

" " " 8th: 91lb.

" " " 14th: 100lb.



Case XI.—Hindu, male, aged 25 years; suffering from MIXED LEPROSY; duration of disease: ten years.

Condition on May 26th: Tubercular thickening of the lobes of both ears, nose, chin; general thickening of face. Discoloration of the skin of the trunk and upper extremities. Fingers of right hand thickened; fourth and fifth fingers of left hand slightly contracted and atrophied; thickening of skin of both upper extremities. Light patches on both thighs and knees; dark patches on both legs, glossy in appearance. Anæsthesia of extremities.

May 27th: "vaccine" injected; when dose was increased to "005cc." a good reaction appeared.

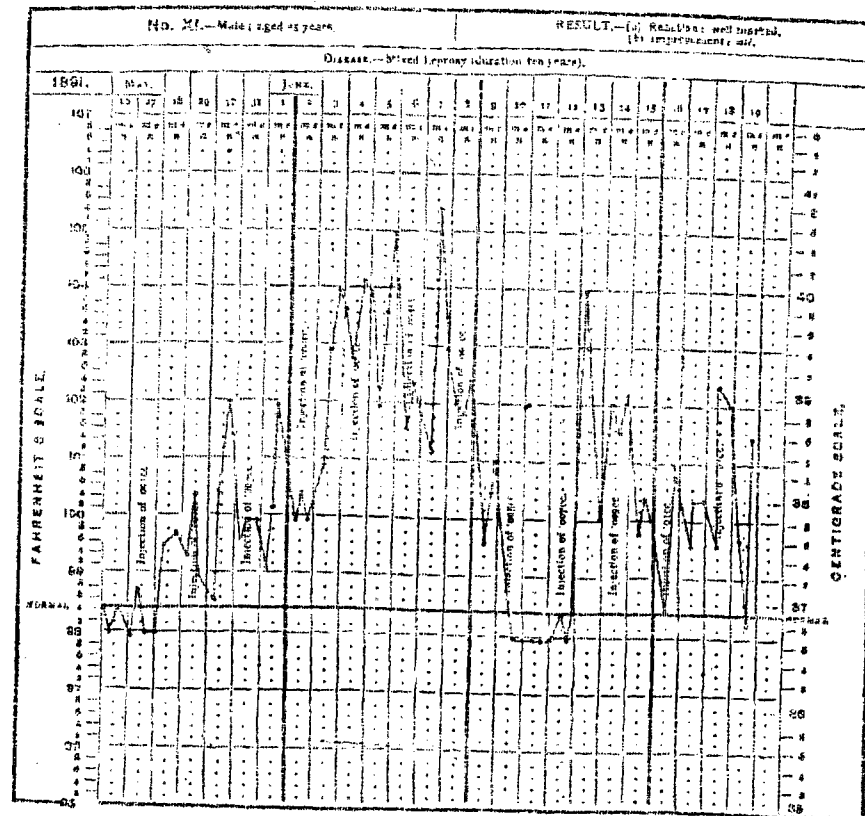
Reaction: well marked.

Improvement: nil; on the other hand, became seriously ill, complaining of pains all over his body and greatly reduced in general health.

Weight on May 27th: 106½ lb.

" " June 8th: 99½ lb.

" " " 14th: 95 lb.



Case XII.—Hindu, male, aged 18 years; suffering from MIXED LEPROSY; duration of disease: six years.

Condition on June 1st: Minute tubercles on the edges of both pinnae; slight tubercular thickening of lobes of ears and nose; discoloration of skin of face. Light anæsthetic patches on both arms; discoloration of skin of both forearms; fingers thickened; fingers of right hand slightly contracted, and also those of left hand. Dark patches above left nipple. Anæsthetic patches on both legs; glossy appearance of skin over both shins; second toe of right foot slightly contracted; second toe of left foot thickened. Total anæsthesia of upper extremities and of both legs.

June 2nd: "001cc." injected, and usual injections given until "005cc." was reached, and the temperature began to rise to 103°. Injections reduced then.

June 12th: "004cc." was injected, but finding that the temperature rose up to 105°, the injections were stopped.

Reaction: Well marked, when "005cc." was given.

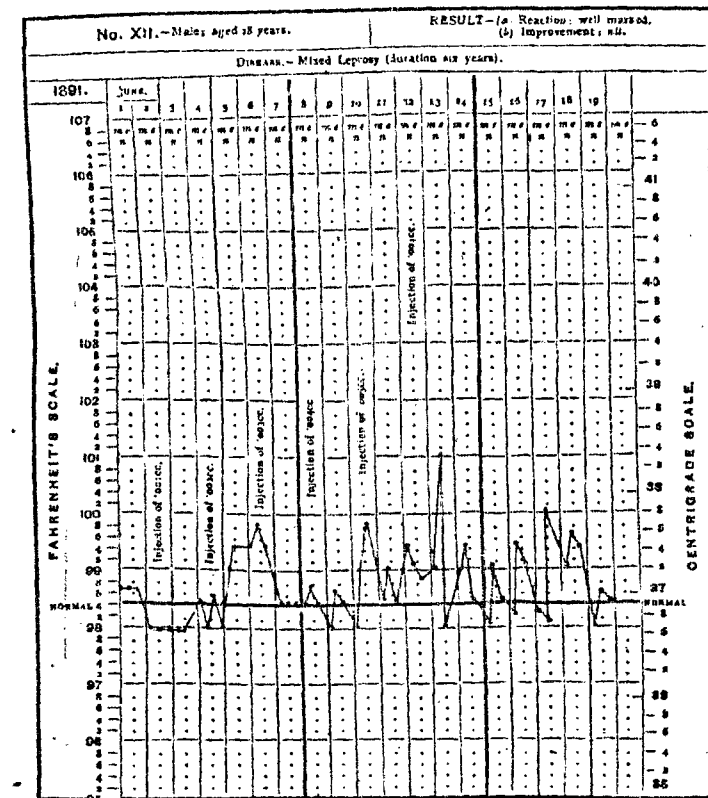
Improvement: nil.

Psoriasis again appeared all over the body (cf. Cases VII, VIII and IX).

Weight on June 1st: 83½ lb.

" " " 8th: 84 lb.

" " " 14th: 80 lb.



CONCLUSIONS.

The following conclusions are based upon the observations and arguments contained in the foregoing report:—

1. Leprosy is a disease *sui generis*; it is not a form of syphilis or tuberculosis, but has striking ætiological analogies with the latter.
2. Leprosy is not diffused by hereditary transmission, and for this reason, and the established amount of sterility among lepers, the disease has a natural tendency to die out.
3. Though in a scientific classification of diseases leprosy must be regarded as contagious and also inoculable, yet the extent to which it is propagated by these means is exceedingly small.
4. Leprosy is not directly originated by the use of any particular article of food, nor by any climatic or telluric conditions, nor by insanitary surroundings; neither does it peculiarly affect any race or caste.
5. Leprosy is indirectly influenced by insanitary surroundings, such as poverty, bad food, or deficient drainage or ventilation, for these by causing a predisposition increase the susceptibility of the individual to the disease.
6. Leprosy in the great majority of cases originates *de novo*, that is, from a sequence or concurrence of causes and conditions, dealt with in the report, and which are related to each other in ways at present imperfectly known.

Practical Suggestions.

Segregation may be voluntary or compulsory, and in either instance partial or complete. Complete segregation has never yet been possible. Both in the Sandwich Islands and in Norway it has failed.

"It appears that there has always been great difficulty in the Sandwich Islands¹ in carrying out a full measure of segregation. This fact comes out in several of the reports; and in the latest of them we see it stated that for some period during the administration as President of the Board of Health of Mr. Gibson, who apparently doubted its efficacy, the work of segregation had been practically brought to an end. At the present time there is an endeavour to enforce rigorously the isolation of lepers."

Again, "the isolation of lepers in the Norway² asylums is not absolute. The doors and gates of the institutions are not locked, and more than once I met some of the inmates in the neighbouring roads. The doctors informed me that they allowed those to go out who showed no ulcerations, and that no cases of consequent infection have ever been traced. The lepers, however, are usually kept in on market days, and at Trondhjem at least, and I believe elsewhere, they are not permitted to enter houses and churches, and to come in close contact with other people."

"To attribute the decline of leprosy in Norway³ to compulsory isolation is entirely erroneous. In the first place no such powers exist or are likely to be sanctioned by the Norse

(¹) P. S. Abraham. Leprosy: A Review of some Facts and Figures. Epidemiological Society's Transactions, Vol. VIII., page 132.

(²) Op. cit., page 135.

(³) W. J. Collins. Note on the Leprosy Revival, Lancet, May 17, 1890, page 1064.

democracy; if they did exist it would be impossible without further accommodation to segregate even the reduced number of lepers in Norway at the present time. Indeed, I met many lepers in the streets of Bergen and on the quay going about their usual vocations. It is not that segregation is stamping out leprosy in Norway, but the increased material prosperity of the people, the growth of foreign trade, the inter-communication with town life, and the opportunities these give for better and more varied subsistence, which have doubtless effected beneficent changes in this direction."

The amount of legislation which at present exists in Norway may be best expressed in the following words of Dr. G. A. Hansen⁴: "Though the disease was steadily diminishing I found that something ought to be done to check the spread of the disease in the country, besides what might be done by the entrance of lepers into our asylums. In consequence I proposed a law which was enacted in 1885. This law gives the Sanitary Commission or Board of Health in each district the right to order a leper, if he will live at home, that he must have his own room at least his own bed, that his clothes ought to be washed separately, that he must have his own eating apparatus,—spoon, fork, knife, etc. If he cannot, or will not comply with this regimen, he is obliged to enter an asylum."

From the above quotations it is at once evident that even in the two countries in which segregation of lepers is commonly believed to be complete, the actual procedure falls far short of this. For India complete compulsory segregation may be considered to be absolutely impracticable. Neither do the conclusions given above as to the nature of the disease justify any recommendation for absolute segregation. The presence

(⁴) G. A. Hansen. Journal of the Leprosy Investigation Committee, No. 2, pages 65-66.

of a leper in a healthy community is a source of danger no greater than the presence of an individual suffering from tuberculosis. Both diseases are contagious in an equal and minimal degree. The amount of ulceration which exists in both diseases is to some extent a measure of the danger of contagion.

It is impossible for the same reasons to advise compulsory partial isolation. Voluntary isolation is, therefore, the only measure left for consideration. Among civilised communities the separation of those suffering from many diseases other than leprosy is encouraged. The voluntary isolation of the leper is, therefore, no exception to this custom. For this reason the Commissioners recommend the adoption of a voluntary isolation as extensive as local circumstances allow. Further, by permitting marriages among lepers, the plan suggested might be the more easily carried out.

In accordance with instructions received from the Committee of the National Leprosy Fund, the Commissioners are required in their final report to describe minutely what they believe to be the best plans for ensuring the efficient carrying out in practice of their recommendations relating to the treatment of lepers.

Conformably with these directions the Commissioners, though they are fully aware that the extent and varying social conditions of the empire may present great practical difficulties, venture to suggest the following schemes.

The Commission are of opinion that the sale of articles of food and drink by lepers should be prohibited, and that they should be prevented from practising prostitution, and from following such occupations, as those of barber and washerman, which concern the food, drink, and clothing of the people generally, quite apart from the dread of a possible infection.

Vagrant and indigent lepers living in the villages and scat-

tered about the country are probably sources of little or no danger. Disgust, and to a certain extent fear, rarely permit their relations to the general community to be intimate, and no harm is likely to result from their soliciting alms by the roadside. The tendency at the present time, however, is for mendicant lepers to leave their homes, to crowd into the large centres of population, and this in the opinion of the Commission should be discouraged. In the cities and towns they herd together, living under circumstances of extreme poverty and filth, and forming communities which are not only offensive to public decency, but constitute from many points of view a menace to the public health. Moreover, in such leper colonies promiscuous and casual alliances are the rule, and the result is that children are born to struggle for existence under circumstances most painful to contemplate. The Commission consider that the best policy in dealing with this matter is to discourage this concentration of lepers in towns and cities, and to this end would suggest that municipal authorities be empowered to by-laws preventing vagrants suffering from loathsome diseases from begging in or frequenting places of public resort, or using public conveyances.

The large Presidency towns and the capitals of provinces in many cases already possess leper asylums, which might be enlarged by municipal funds or private subscriptions. Asylums should be built near towns where they do not already exist, and the authorities should have the power of ordering lepers infringing the regulations either to return to their homes or to enter an asylum.

Competent medical authority should always be consulted before action is taken under such by-laws.

In no case would the Commissioners suggest an Imperial Act, especially directed against lepers as such, for these are far less dangerous to a community than insane or syphilitic people.

The effect of such bye-laws in large towns would be an emigration into the surrounding country, and a furtherance of the scheme now to be proposed for establishing experimental leper colonies or farms in rural districts.

The experiment of the leper farm in Cyprus⁵ has succeeded. Though unwilling to argue from a small island to a large empire, the Commission are of opinion that the success of leper colonies, such as that of Sialkot, which is isolated in the centre of a large agricultural district, and where lepers with their wives and families cultivate the soil, leads to the belief that similar farms scattered over the country would be productive of practical good.

Land might be granted, cheap buildings raised, seeds distributed, and work supplied. The produce might partially support the colony, and a small fixed money allowance might be given, or a small bounty be paid on the produce raised by each leper.

Comparatively few children would be born, and these should, if possible, be removed to Orphanages. Only a certain number of the latter would be required, as the inmates might be discharged as soon as they were old enough to support themselves. The advantages of such a method are fully illustrated in the Almora Orphanage.

In conclusion, the Commissioners believe, from the considerations and arguments adduced in the foregoing report, that neither compulsory nor voluntary segregation would at present effectually stamp out the disease, or even markedly diminish the leper population, under the existing conditions of life in India. It can only be hoped that by means of improved sanitation and good dietetic conditions a diminution of leprosy will result. The Commission agree with most authorities in believing that the decline of leprosy in Europe has been due

(⁵) Dr. Heidenstam, C.M.G. Report on Leprosy in Cyprus, 1890, page 13.

principally to improved hygienic habits and surroundings, and increased material prosperity.

English Members:

BEAVEN RAKE.

GEORGE A. BUCKMASTER.

ALFRED A. KANTHACK.

Indian Members:

ARTHUR BARCLAY, *Surgeon-Major, Bengal Medical Service.*⁶

SAMUEL J. THOMSON, *Surgeon-Major, Bengal Medical Service.*

SIMLA:

August, 21st 1891.

⁽⁶⁾ The name of the late Surgeon-Major A. Barclay is appended to this report, as the conclusions and suggestions were drawn up previous to his death, and were known to be in accordance with his views.

Appendices I and II are printed separately for the following reasons. In the interests of the investigation, one section of the Commission commenced enquiries at Almora, while the other began work at Simla. Subsequently, when the two sections of the Commission met, it was found that the enquiry had proceeded so far that it would be preferable to continue experiments separately, especially as there was not sufficient room in the laboratory erected by the Government of India at Simla for the entire Commission to work together with facility. The two sections met at intervals, compared their observations, and discussed details of their work. Each Appendix consequently represents independent observations for which each section is separately responsible.

APPENDIX I:

Laboratory Work done in Almora and Simla.

By

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- I.—The Bacillus Lepræ.
- II.—Distribution of the Bacillus within the Body.
- III.—Distribution of the Bacillus outside the Body.
- IV.—Vaccination.
- V.—Cultivation Experiments.
- VI.—Transmissibility of the Disease by Experiment.

Explanation of Plate II.

FIG. 1.—Surface pellicle on bouillon. This was the original culture from blister fluid in which bacilli had multiplied. The broken capillary tube containing this fluid is seen at the bottom of the culture. A surface pellicle, general slight turbidity, and just a faint bottom deposit are seen. Appearance on twelfth day after introduction of the capillary tube.

FIG. 2.—First generation on gelatine three days after inoculation from culture of Fig. 1. Central pellicle, and commencing fluidity of gelatine. Absence of growth in the needle track to any extent.

FIG. 3.—Appearance of the gelatine culture of Fig. 2 twenty days later, showing a thick tenacious surface scum which is capable of being drawn out into threads, and a clear liquid gelatine with deposits of ropy sticky culture.

FIG. 4.—Culture on Agar. Piece of tubercle from centre of the lobe of the ear. The inoculation was made on May 22nd. Appearance six weeks subsequently. No trace of bacilli of any kind, but a rich growth starting from the tubercle of *staphylococcus albus* and *cereus*.

FIG. 5.—First generation on Agar from original bouillon. Appearance of growth on third day.

FIG. 6.—Same culture as Fig. 5, showing appearance at end of sixth day.

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Explanation of Plate I.

FIG. 1.—Culture on May 28th from bouillon inoculated on May 14th, with capillary tube containing blister fluid in which were bacilli. In the specimen the bacilli are bright red. Stained with Ziehl's solution for six hours, then 25 per cent. nitric acid and 60 per cent. alcohol. Drawn with Camera Lucida. Winkel Homog. Immersion $\frac{1}{4}$, ocular 4.

FIG. 2.—Culture on Agar on June 10th, 4th generation in ocu-
lated on June 8th. Stained and drawn as above.
Winkel Homog. Immersion $\frac{1}{4}$, ocular 4.

FIG. 3.—Culture on plate, 2nd generation of June 18th, from
plate culture of two days earlier which was in-
oculated from 4th generation on Agar of June 8th.
Stained and drawn as above. Winkel Homog.
Immersion $\frac{1}{4}$, ocular 4.

Explanation of Plate III.

FIG. 1.—Culture of bacillus in bouillon on eleventh day (original culture). Carbol-fuchsin; water; 20 per cent. nitric acid. Winkel Homog. Immersion $\frac{1}{4}$, ocular 4.

FIG. 2.—Same culture as Fig. 1; five days later, showing hull. Gram's Method, Winkel Homog. Immersion $\frac{1}{4}$, ocular 4.

FIG. 3.—Second generation on gelatine; three days old. Carbol-fuchsin, water, and subsequent 20 per cent. nitric acid. Winkel Homog. Immersion $\frac{1}{4}$, ocular 4.

FIG. 4.—Second generation on Agar from first generation on Agar; two days old. Carbol-fuchsin; water, and subsequent 20 per cent. nitric acid. There is a hull round a few bacilli, and being drawn in water, these appear rather large.

FIG. 5.—First generation on Agar from original; three days old, showing the commencing grouping together of the bacilli owing to the development of a mucin (?) hull. Magnification as above.

FIG. 6.—A small colony of first generation on Agar; five days old, showing peculiar grouping of bacilli into heaps very comparable to the grouping in tissues. Methyl Blue. Winkel $\frac{1}{4}$, ocular 3.

FIG. 7.—Culture of bacillus resembling the vacuolated bacilli figured by Neisser. Magnification as above.

FIG. 8.—Appearance exhibited by bacilli described by Neisser as Kugel Bacteria. Magnification as above.

All the figures were drawn with the Camera Lucida.

The following is a record of Laboratory work which was done at Almora and Simla by Drs. Rake, Buckmaster, and Surgeon-Major Thomson.

I.—THE BACILLUS LEPRÆ.

The microscopical examination of the pathological neoplasms or tubercles which are characteristic of one form of leprosy was first made by Virchow in 1859.¹ The appearances presented by the nerves in the anæsthetic form are also figured by the same observer. In both these forms of the disease typical nucleated lepra-cells were seen which contained granular matter. Vandyke Carter by his researches, carried on independently in Bombay, constantly found these specific structural elements present in leprosy,² and Klebs³ in 1873 drew attention to the fact "that in freshly extirpated tubercles, groups of bacteria, which in form and arrangement totally differed from those met with in other diseases, could be seen without difficulty." Armauer Hansen in 1868 and 1873 described movable rod-shaped bodies in fresh tubercles, and yellow spherical masses which possibly were zooglœa masses in older ones. In 1880 the Norwegian observer, who during the preceding seven years had shown his preparations to numbers of medical men, published a record of his experiments and observations accompanied with figures, in which the granular masses within the lepra-cells were shown to be heaps of bacilli.⁴ At this period the work of Koch⁵ and Weigert,⁶ which is the foundation of scientific bacteriological method, was all but unknown, and with the exception of the *Bacillus Anthracis*⁷ and some ill-defined bacteria connected with Pyæmia and Septicæmia,⁸ scarcely a single definite pathogenic organism had been discovered.⁹ Among

(1) Die Krankhaften Geschwülste, Bd. II, p. 494.

(2) On Leprosy and Elephantiasis; Vandyke Carter, 1874, pp. 169, 170, Plate XII.

(3) Archiv. f. Experiment. Path. und Pharm., 1873 (quoted from Carter).

(4) Virchow's Archiv. 1880, Bd. 79, p. 31.

(5) Cohn's Beiträge zur Biologie der Pflanzen Bd. II, Heft 3; and Wundinfectionskrankheiten, 1873.

(6) Sitzung der Schles. Gesellsch. für vaterl. Cultur, 1875.

(7) Seen by Rayer and his pupil Davaine in 1851.

(8) Burdon Sanderson, Report of the Medical Officer of the Privy Council, Series II, No. 3.

(9) The Bacilli of Septicæmia in mice and rabbits, and also certain pathogenic micrococci were fully described by Koch in 1878.

the great number of observers who have verified the accuracy of Hansen's discovery, the work of Neisser, who by the aid of the Koch-Weigert methods, placed this discovery beyond question, must be mentioned.¹⁰ Sufficient time has now passed for it to be possible to confidently affirm that the presence of the *Bacillus Lepræ* in the new growths of leprosy is absolutely characteristic of the disease. Indeed, this bacillus has a specific relationship in the causation of leprosy. No leper is free from this organism, and in the bodies of those suffering from other diseases it never occurs. For these reasons the *Bacillus Lepræ* has been a subject of much study to those who have concerned themselves with the disease, and the most important results which are at present known will be briefly given.

The *Bacillus Lepræ* is a rod-like parasite, the length of which is one-half to three-quarters the diameter of a human red blood-disc,¹¹ in breadth about one-fifth of the length. It is straight, or slightly bent, with extremities that are pointed or slightly round. The bacillus possesses a protoplasmic content, in which clear spaces may at times be seen (endogenous spores?), surrounded by a delicate membrane. According to De Bary this membrane is only the most compact internal layer of a hull of material which may swell up, take a gelatinous character, and form an envelope to the bacillus. With certain reagents, such as iodine solution, the coherent rod may present the appearance of a row of minute spheres or cocci (kokkothrix). Whether these, morphologically, are true sphaerobacteria or only a granular thread is uncertain. This appearance can also be produced by treatment with strong sulphuric acid, by staining with borax-methyl-blue and subsequent decolorisation in water or alcohol, and further by staining with hæmatoxylin or osmic acid. Neisser¹² holds the view that the *Bacillus Lepræ* is rod-shaped and possesses a hull, the innermost layer of which retains such a stain as fuchsin better than the outer layers, and this obscures the true structure of the bacillus. The same observer states that the contents of a bacillus are (1) highly refracting oval spores; (2) ordinary protoplasm which scarcely stains at all, or if it does is easily bleached by acids; (3) granules. These latter become visible under the influence of the reagents mentioned above and give rise to the kokkothrix aspect.

(10) Breslauer Aerztl. Zeitschr. 1879, Nos. 20, 21, and Virchow's Archiv. 1881, Bd. 84, p. 514.

(11) A human red blood disc is 7.3 micro-millimeters (733 μm.).

(12) Neisser, Archiv. f. Dermat. und Syph. 1889. Quoted from Baumgarten's Jahresbericht, 1889.

The bacillus has been described as both motile and non-motile, possibly this is true for young and old bacilli respectively. The bacillus multiplies by fission; a bacillus grows to a certain length and then divides into two, and the process is repeated. Isolated spores which have become free have never yet been seen.

In form and size *Bacillus Lepræ* greatly resembles *Bacillus Tuberculosis*. A distinction is considered to exist between these in their behaviour to staining reagents, and this rests upon a micro-chemical reaction dependent upon the behaviour of the investing membrane of the bacillus towards acids, alkalies, and aniline dyes.¹³ The staining procedure employed as diagnostic of the *Bacillus Lepræ* is as follows: 1st, treatment of the section of tissue, or film fixed upon a cover-glass, with warm Ziehl's solution¹⁴ for twelve minutes; 2nd, decolorisation of the specimen in 25 per cent. nitric acid; 3rd, washing in 60 per cent. alcohol; 4th, washing in distilled water. Cover-glass specimens are at once examined in water, or after drying, in xylol-balsam. Sections are treated with absolute alcohol and removed to bergamot oil before mounting in balsam. A saturated solution of acetate of potash is the best medium in which to mount specimens, as the colour disappears less rapidly. The *Bacillus Tuberculosis* is not stained by so short an immersion in Ziehl's solution, and all other bacilli that were stained would have been wholly decolorised by the acid, while the *Bacilli Lepræ* resist this bleaching¹⁵ and stand out in the field of the microscope as bright red rods (Baumgarten). The following also stain well by the above method and exhibit a resistance to strong mineral acids which is almost as great as that shown by Tubercle and Leprosy Bacilli: (1) keratin tissue; (2) the spores of a large kind of bacillus found in the intestinal canal and described by Koch; (3) the spores of mucor; (4) certain pseudo-bacilli figured by Celli and Guarnieri which are probably crystals of fatty acid; (5) the Syphilis, or Smegma Bacillus, which to some

(13) Ehrlich's early papers are in Zeitschrift f. klin. Med. Bd. 1, 1880; Ibidem Bd. 11, 1881; Deutsch. Med. Wochen. 1882, No. 19; Charité Annalen 1886. The views of Ehrlich with reference to the behaviour of *Bacillus Lepræ* and *Bacillus Tuberculosis* towards aniline dyes and also to acids, are, that, firstly, the membrane of these bacilli is only slightly permeable to acids; and, secondly, that the acid chemically changes this membrane, so that the colour held by the protoplasm cannot diffuse outwards. The value of the addition of alkalies, aniline or phenol to the dye depends upon the facts that the membrane becomes more permeable, and a true combination of these reagents with the dye ensures a more brilliant staining effect.

(14) Water 100 cub. cent.; Crystallized Carbolic Acid 5 grammes; Alcohol 10 cub. cent.; Fuchsin 1 gramme (Ziehl-Neelsen).

(15) As a fact, the bacilli do lose their colour wholly or in part in the acid, but regain it in the treatment with alcohol and water. A piece of silk treated with aqueous methyl-violet similarly reacts by losing colour in acid and recovering this in water.

extent behaves similarly, due to the presence of a hull of fatty material. Leprosy Bacilli may also be differentiated from those of Tubercle by treatment with potash solution 1:12. The bacilli appear as clear rather thick rods. If a drop of watery methyl-violet be now added to the specimen, only the *Bacillus Lepre* stains, while the other remains colourless (Baumgarten). However, the *Bacillus Tuberculosis* can also be stained with watery aniline dyes¹⁶ and the *Bacillus Lepre* with alkaline methyl-blue.¹⁷ The method with Bor-fuchsin¹⁸ has not succeeded in our hands; the Leprosy Bacilli remained stained. The staining behaviour of *Bacillus Lepre*, according to Neisser,¹⁹ may be summarised briefly as follows: fuchsin, gentian and methyl-violet, dahlia, especially in weak acid solution, stain the bacillus well; methylene-blue, nigrosin, aurantia, methyl-green and cosin have no staining effect; Bismarck brown does not stain whether in acid or alkaline solution, though Koch has obtained a slight coloration with vesuvin. An eosin-alum-haematoxylin solution (Ehrlich) stains the nuclei of tissues blue, the cell protoplasm rose, and the bacilli orange. The coloration of the bacilli is always less than that shown by micrococci, and at times the colour disappears in a day or so. The methods of Kühne and Unna having reference chiefly to the manner of disposition of the bacilli within the tissues and organs of the body, have not been employed by us. Gram's method stains the bacilli well, and the kokkothrix appearance is admirably seen.

Though the work of Weigert, Ehrlich, Kühne, Unna and others has to some extent changed the technology of staining from an empirical to a scientific basis, much is still required before a definite staining procedure can be considered as a definite micro-chemical reaction. At present the differential diagnostic method for the *Bacillus Lepre* and *Bacillus Tuberculosis* given above is generally recognized as the best means for detection of the Leprosy Bacillus; but it may be considered an open question whether this is absolute. The grouping of the bacilli in clumps in cells of specific shape and

(16) Baumgarten, Path. Mykologie, Vol. II, page 645. Wesener, Centralbl. f. Bact., II, Parasit, Vol. II, 1887.

(17) Koch, Berlin, klin. Woch. 1882. According to Bordoni-Uffreduzzi a distinction exists between *Bacillus Lepre* and *Bacillus Tuberculosis* in that only the latter stains with methyl-blue.

(18) Lüdimoff. Abstract of paper in Baumgarten's Jahresbericht, Vol. I, 1888. Stain in the following solution: Fuchsin 0.5 gramme; Boracic Acid 0.5 gramme; Absolute Alcohol 15.0 cub. cent., water 20 cub. cent.; decolorise in 1:5 Sulphuric Acid. The *Bacillus Lepre* decolorises, but not the *Bacillus Tuberculosis*.

(19) Virch. Archiv. 1881.

structure²⁰ is, however, characteristic of the *Bacillus Lepre* within the tissues of the body. This aggregation may be due to the nature of the hull of the bacillus, for though, according to Lutz and Unna, the *Bacillus Tuberculosis* possesses a similar hull, this is rarely grouped into heaps, and even the arrangement within giant cells in no way resembles the grouping that is presented by the *Bacillus Lepre*.

Bacilli which have been in alcohol stain better than when seen in fluid just expressed from a tubercle. A very prolonged treatment with warm Ziehl's solution will also enable bacilli, other than *Bacillus Lepre* or *Bacillus Tuberculosis*, to resist the effect of acids. Masses of micrococci also retain the stain. Spina's statement²¹ that putrefactive bacteria treated with 2 per cent. tannin stain like the above bacilli we did not succeed in confirming.

II.—DISTRIBUTION OF THE LEPROSY BACILLUS WITHIN THE BODY.

In the absence of autopsies this subject could not be dealt with as fully as might have been wished. From the records of various observers, it is however by this time well known that the bacillus of leprosy has been found in most of the tissues and viscera of the body, though it occurs in some, such as the liver and spleen, far more frequently than in others, such as the kidney and brain.

Observations on the following fluids, secretions, and excretions of the body were made as opportunity offered at Almora, Simla, and Hyderabad.

Fluids.	
Blood.	Juice from leprous tubercle.
Blister fluid.	Discharge from leprous ulcer.
	Material from thickened nerve.
Secretions.	
Saliva.	Vaginal mucus.
Excretions.	
Urine.	Sputum.
Fæces.	Menstrual discharge.

(20) With the question whether the bacilli are within cells, or collected into groups lying exterior to these, we have not concerned ourselves. The latter view which is held by Unna and exhibited by his "Trocken Methode" is also that of Kühne. The iodine-pararosaniline-method also shows the rod-like bacilli to be a coccus series, similar to that figured by Zopf for *Bacillus Tuberculosis* (vide Die Spaltpilze).

(21) Quoted by Stricker in Infektionskrankheiten.

FLUIDS.

Blood.

Köbner is the only pathologist who claims to have found Leprosy Bacilli in the blood.

All other observers have failed, even during acute outbreaks of the disease, and it may fairly be doubted if the bacillus can live in the blood.

Twenty-three cover-glasses prepared from blood obtained from six lepers failed in any case to show Leprosy Bacilli. It is worthy of note that even where the blood was obtained by section of a tubercle, the results were negative. The following table shows the results of examination of blood:—

No.	Name.	AGE.		Form.	Years afflicted.	Source of Blood.	Date.	No. of cover-glasses.	Result of Microscopic Examination.
		M.	F.						
1	Amarua	25	...	M	13	Tuberculated hand	25-3-91	4	1, 2, 3, 4. Small rods stained blue. No Leprosy Bacilli.
2	"	25	...	"	13	Anæsthetic skin of arm.	25-3-91	2	1. Rods of various lengths, not taking fuchsin. 2. Rods, stained blue.
3	Phaganiya	32	...	A	12	Vein of anæsthetic hand.	25-3-91	4	1, 2, 3, 4. Debris only.
4	Jaikishen	35	...	M	29	Normal skin of fore-arm.	30-3-91	3	1, 2. Cocci. 3. Cocc and short rods. No Leprosy Bacilli.
5	Fakira	30	...	M	10	Normal skin of fore-arm.	30-3-91	2	1, 2. Blood disc. No bacilli.
6	Puniya	30	...	M	22	Normal skin of fore-arm.	30-3-91	2	1. A few red cocci. 2. Negative.
7	Bishan Singh	30	...	T	10	Back of finger between two tubercles.	7-4-91	2	1, 2. Debris. No bacilli.
8	"	30	...	"	10	Incised tubercle of hand.	7-4-91	2	1, 2. Debris. No bacilli.
9	"	30	...	"	10	Incised tubercle of wrist.	13-4-91	2	1, 2. No Leprosy Bacilli.

Blister Fluid.

The observations and experiments made on blister fluid are fully explained in another part of the report, for it was by the application of blisters over tubercles that it appeared possible to separate living Leprosy Bacilli from the tissues, and subsequently to grow them in blister serum and other media. Little more than an enumeration of the observations need, therefore, be here given. The subjoined table shows that blisters on various parts of the body were raised on five different patients. Fifty-nine cover-glasses were prepared, and of these, nine specimens from three different patients showed Leprosy Bacilli in greater or less quantities. It must be noted that all these positive cases were in fluid obtained from blisters over actual tubercles. In blisters raised over anæsthetic patches or normal skin no bacilli were in any case found.

No.	Name.	AGE.		Form.	Years afflicted.	Material examined.	Date.	No. of cover-glasses.	Result of Microscopic Examination.
		M.	F.						
1	Puniya	30	...	M	22	Fluid from blister over tubercle of cheek.	27-3-91	4	1. Swarms of bacilli of various lengths; some very long; some in nests; deeply stained with fuchsin. 2, 3, 4. A few red bacilli.
2	"	30	...	"	22	Fluid from blister over right superciliary tubercle.	27-3-91	3	1. Weigert's threads stained red. No bacilli seen. 2, 3. A few red bacilli.
3	Phaganiya	32	...	A	12	Fluid from blister over anæsthetic patch of back.	28-3-91	2	1. Nothing beyond a few pieces of shreddy material. 2. A few red bacilli.
4	"	32	...	"	12	Fluid from blister over normal skin.	22-3-91	2	1. No bacilli. 2. A few red bacilli.
5	Fakira	30	...	M	10	Fluid from blister over tubercle of nose.	31-3-91	2	1. Quantities of Leprosy Bacilli. 2. A few red bacilli.
6	"	30	...	"	10	Fluid from blister over non-tuberculated back.	31-3-91	2	1. Numerous leucocytes. No bacilli. 2. A few red bacilli.
7	Jaikishen	35	...	M	29	Fluid from blister over non-tuberculated back.	31-3-91	2	1. Debris. No bacilli. 2. A few red bacilli.

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No.	Name.	AGE.		Form.	Years afflicted.	Material examined.	Date.	No. of cover-glasses.	Result of Microscopic Examination.
		M.	F.						
8	Jaikishen	35	...	M	29	Fluid from blister of back.	1-4-91	3	1. Large bacteria. No bacilli. 2. Debris. No bacilli. 3. A few red bacilli.
9	"	35	...	"	29	Fluid from blister of back.	1-4-91	2	1. Chain of short thick bacilli. No Leprosy Bacilli. 2. Bacilli and cocci. No Leprosy Bacilli.
10	Puniya	30	...	"	22	Fluid from blister on tuberculated ear.	1-4-91	3	1. Debris. No bacilli. 2. Bacilli and cocci. No Leprosy Bacilli.
11	"	30	...	"	22	Fluid from blister on tuberculated ear.	1-4-91	2	1. Few other bacilli. No Leprosy Bacilli. 2. Bacilli and cocci. No Leprosy Bacilli.
12	Jaikishen	35	...	"	29	Fluid from blister of back.	1-4-91	2	1. Few bacilli stained blue. No Leprosy Bacilli. 2. Chain of bacilli stained blue. No Leprosy Bacilli.
13	"	35	...	"	29	Fluid from blister over tuberculated ear.	3-4-91	1	1. Few suspicious bacilli taking pink stain. 2. Leucocytes. No bacilli.
14	Fakira	30	...	"	10	Fluid from blister over tuberculated nose.	4-4-91	2	1. Few Leprosy Bacilli, also a number of unstained bacilli. 2. Debris. No bacilli.
15	Bhaguli	...	...	...	...	Fluid from blister over anæsthetic patches on back.	4-4-91	2	1. Numerous leucocytes. No bacilli. 2. Debris. No bacilli.
16	Fakira	30	...	M	10	Fluid from blister over tubercle of face.	6-4-91	1	1. Numerous unstained bacilli. No Leprosy Bacilli.
17	Bishan Singh	30	...	T	10	Fluid from blister over tubercle of nose.	7-4-91	2	1. Few Leprosy Bacilli. 2. Debris. No bacilli.
18	"	30	...	"	10	Fluid from blister over tubercle of wrist.	8-4-91	4	1. Few micrococci and bacilli stained blue. 2, 3, 4. Debris. No bacilli.
19	"	30	...	"	10	Fluid from blister over tubercle of cheek.	8-4-91	2	1. Few micrococci and bacilli stained blue. 2. Debris. No bacilli.

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No.	Name.	AGE.		Form.	Years afflicted.	Material examined.	Date.	No. of cover-glasses.	Result of Microscopic Examination.
		M.	F.						
20	Bishan Singh	30	...	T	10	Fluid from blister over tubercle of forehead.	11-4-91	2	1. Leucocytes. No bacilli. 2. Debris. No bacilli.
21	"	30	...	"	10	Fluid from blister over tubercle of cheek.	11-4-91	2	1. Leucocytes. No bacilli. 2. Debris. No bacilli.
22	Puniya	30	...	M	22	Fluid from blister over tubercle of forehead.	11-4-91	2	1. Leprosy Bacilli and leucocytes. 2. No Leprosy Bacilli.
23	"	30	...	"	22	Fluid from blister on non-tuberculated back.	11-4-91	2	1. Quantities of leucocytes. No bacilli. 2. No Leprosy Bacilli.
24	Fakira	30	...	"	10	Fluid from blister over tubercle of lip.	14-4-91	2	1. Pus cells and bacteria. 2. Debris. No bacilli.
25	"	30	...	"	10	Fluid from blister over healthy back.	14-4-91	1	1. No bacilli.
26	Puniya	30	...	"	22	Fluid from blister over tubercle of forehead.	14-4-91	2	1. No Leprosy Bacilli. 2. Debris. No bacilli.
27	"	30	...	"	22	Fluid from blister over healthy back.	14-4-91	1	1. Leucocytes. No bacilli.
28	Bishan Singh	30	...	T	10	Fluid from blister over tubercle of face.	14-4-91	1	1. Debris. No bacilli.
29	"	30	...	"	10	Fluid from blister over healthy back.	14-4-91	1	1. Leucocytes. No Leprosy Bacilli.

Juice from leprous tubercle.

It may safely be affirmed that Leprosy Bacilli are always found in cutaneous and other tubercles at some period or other of their existence. The failure to find them is due either to error of preparation or observation, to the fact that no bacilli have happened to be expressed on to the cover-glass, or to the fact that the tubercle is old and degenerating, and the bacilli are consequently dead. That it is not always easy to obtain bacilli from leprous tubercles, is shown by the observations recorded above that no bacilli were found in blood from tuberculated tissue. Evidently more than simple section of the tubercle is usually required to extract the bacilli. Compression must

also be employed as recommended by Manson, or the blister method detailed above. So well known is the association of bacilli with leprous tubercles, that it was hardly considered necessary to make observations on this point. Such as were made were for the purpose of controlling other work, such as blister or inoculation experiments. The results are given in the next table, and it will be seen that only three observations absolutely failed to show them, while in another they were doubtful.

No.	Name.	AGE.		Form.	Years afflicted	Source of Juice.	Date.	No. of cover-glasses.	Result of Microscopic Examination.
		M.	F.						
1	Puniya	30	...	M	22	Tubercle of ear	25-3-91	4	1, 2, 3. Quantities of Leprosy Bacilli free and in cells. 4. Negative.
2	"	30	...	"	22	"	31-3-91	2	1, 2. Quantities of Leprosy Bacilli.
3	"	30	...	"	22	"	14-4-91	1	1. Clusters of Leprosy Bacilli.
4	Fakira	30	...	"	10	"	14-4-91	1	1. Doubtful bacilli taking fuchsin.
5	Bishan Singh	30	...	T	10	" of wrist	14-4-91	1	1. Debris. No bacilli.
6	"	30	...	...	10	" of finger	15-4-91	1	1. Swarms of Leprosy Bacilli.
7	"	30	...	...	10	" of wrist	15-4-91	1	1. Cocci stained blue. No bacilli.
8	"	35	...	T	...	" of face	29-6-91	1	1. Few Leprosy Bacilli.
9	Rahim Khan	35	...	"	21	" of ear	12-7-91	2	1. Clusters of Leprosy Bacilli.

Discharge from leprous ulcers.

In the discharge from tuberculated ulcers Leprosy Bacilli, both free and in cells, are more beautifully brought out by staining than perhaps in any other fluid or tissue. Whether it is that the bacilli in

this discharge have been so macerated as to be divested of their mucin-like hull is a question, but the fact remains. In the discharge from anæsthetic ulcers, on the other hand, they could not be found.

At Almora an experiment was made in which a leper washed his tuberculated and ulcerated feet in a basin of water. Examination of cover-glass preparations from this water showed Leprosy Bacilli in every specimen. The experiment was repeated at Simla with like results, but plate cultivations from this water failed to produce any colonies of Leprosy Bacilli. It is possible to argue from these experiments that though the bacilli are thrown off in great numbers from tuberculated ulcers, they are not living. It must, however, be remembered that discharges from open ulcers are so full of microbes of every description, that the Leprosy Bacillus, which does not grow rapidly or very vigorously, might easily be over powered in the struggle for existence with other organisms. An account of the different discharges examined is given in the next table:—

No.	Name.	AGE.		Form.	Years afflicted.	Source of Discharge.	Date.	No. of cover-glasses.	Result of Microscopic Examination.
		M.	F.						
1	Phaganiya	32	...	A	12	Ulcer on anæsthetic hand.	25-3-91	2	1. Doubtful bacilli, probably not pathogenic. 2. Debris only.
2	Fakira	30	...	M	10	Tuberculated ulcer on dorsum of foot.	3-4-91	2	1, 2. Quantities of Leprosy Bacilli singly and in groups.
3	"	30	...	"	10	Tuberculated ulcer on side of sole.	3-4-91	2	1, 2. Quantities of Leprosy Bacilli, but not so numerous as in last specimen.
4	Bishan Singh	30	...	T	10	Water in which tuberculated ulcers of feet had been washed.	13-4-91	4	1, 2, 3, 4. Epithelial squamous nucleated cells, dirt, and Leprosy Bacilli. [In many cases the bacilli were in distinct clumps, i. e., the cells were loaded with them.]
5	Fakira	30	...	M	10	Water in which tuberculated ulcers of feet had been washed.	13-4-91	4	1, 2, 3, 4. Leprosy Bacilli as in last four specimens.
6	Rahim Khan	35	...	T	21	Water in which tuberculated ulcers of feet had been washed.	10-6-91	4	1, 2, 3. Leprosy Bacilli. 4. Negative.

Material from thickened nerve.

Four cover-glass preparations from a leprosy ulnar nerve, operated on by Surgeon-Major Lawrie at Hyderabad, were examined, but no bacilli were found. Comparatively little value can, however, be attached to this observation, for bacilli in leprosy nerves often escape notice unless sections are made. This, of course, was impracticable in the above case.

SECRETIONS.

Saliva.

In many of the cases in which bacilli were found in the saliva, the tongue was tuberculated and in some cases ulcerated. It is, therefore, not a matter of surprise that bacilli should be present in this secretion. Indeed, so frequently and rapidly do leprosy tubercles of the tongue, throat, and larynx ulcerate, that the wonder is that bacilli are not more frequently found in saliva.

The following table shows the number of specimens of saliva examined, and it will be seen that in only eight out of twenty-two observations were characteristic bacilli seen:—

No.	Name.	AGE.		Form.	Years afflicted.	Source of Saliva.	Date.	No. of cover-glasses.	Result of Microscopic Examination.
		M.	F.						
1	Puniya	30	...	M	22	Over tuberculated tongue.	27-3-91	2	1, 2. Epithelioid cells in which lie spherical masses filled with Leprosy Bacilli in stages of apparent disintegration.
2	"	30	...	"	22	Over tuberculated tongue.	28-3-91	2	1, 2. Debris. No bacilli.
3	Jaikishen	35	...	"	29	Apparently normal mouth.	28-3-91	2	1, 2. Small blue rods and cocci.
4	"	35	...	"	29	Apparently normal tongue.	30-3-91	2	1. Squamous epithelium and leucocytes. 2. Bacteria and leucocytes.

No.	Name.	AGE.		Form.	Years afflicted.	Source of Saliva.	Date.	No. of cover-glasses.	Result of Microscopic Examination.
		M.	F.						
5	Puniya	30	...	M	22	Over tuberculated tongue.	30-3-91	2	1, 2. Debris. Squamous epithelium, leptothrix and bacteria.
6	Fakira	30	...	"	10	Apparently normal mouth.	30-3-91	2	1, 2. Quantities of small blue rods and cocci.
7	Puniya	30	...	"	22	Over tuberculated tongue.	3-4-91	2	1, 2. No Leprosy Bacilli.
8	Bishan Singh	30	...	T	10	Over tuberculated ulcer of tongue.	10-4-91	2	1, 2. Several Leprosy Bacilli lying over blue masses of epithelium.
9	"	30	...	"	10	Over tuberculated ulcer of tongue.	11-4-91	2	1, 2. Some Leprosy Bacilli, also leptothrix and salivary cells. 2. No bacilli.
10	Rahim Khan	35	...	"	24	Over tuberculated ulcer of tongue.	22-5-91	4	1, 2, 3. Showed clumps of Leprosy Bacilli. 4. Negative.

Vaginal Mucus.

Surgeon-Major H. D. Cook kindly sent specimens from two cases in the Madras Asylum.

The first specimen was taken on 24th June, 1891, from a patient, aged 16, suffering from mixed leprosy. Ten cover-glass preparations were examined on 17th July, 1891, and showed an immense number of decolorised bacilli with a few faintly stained ones. There were also staphylococci and beaded rods, sometimes stained pink. In one specimen were a few spore-bearing bacilli, the spores being a deep red. There were no undoubted Leprosy Bacilli.

The second specimen was taken on 24th June, 1891, from a tuberculated leper, aged 18. Ten cover-glasses were examined on 17th July, 1891, and showed numerous staphylococci, isolated bacteria, and micrococci. In one specimen was a mass of six or seven highly stained short rods which were possibly Leprosy Bacilli.

Leprosy Bacilli have been described in vaginal secretion by one or two observers (Kalindero and Babés). The bearing of these observations on the question of inoculability of leprosy is obvious.

EXCRETIONS.

Urine.

The urine of six lepers was examined, two of them being mixed cases, three anæsthetic, and one tuberculated. Four cover-glasses from each case were taken, making twenty-four observations in all. In no case were Leprosy Bacilli found. This is not surprising, for very rarely are Leprosy Bacilli found in kidneys examined after death.

The results obtained from urine are given below:—

No.	Name.	AGE.		Form.	Years afflicted.	Material examined.	Date.	No. of cover-glasses.	Result of Microscopic Examination.
		M.	F.						
1	Puniya	30	...	M	22	Urine	10-4-91	4	1, 2, 3, 4. Epithelium. No Leprosy Bacilli.
2	Fakira	30	...	"	10	"	10-4-91	4	Ditto ditto.
3	Bishan Singh	30	...	T	10	"	10-4-91	4	Ditto ditto.
4	Ratanah	18	...	A	13	"	10-4-91	4	Ditto ditto.
5	Gumaniya	35	...	"	19	"	10-4-91	4	Ditto ditto.
6	Phagania	32	...	"	12	"	10-4-91	4	Ditto ditto.

Fæces.

This excretion was examined in five lepers, two anæsthetic, two mixed, and one tuberculated. Sixteen cover-glass preparations were made, and in one from a mixed case Leprosy Bacilli were found. In this patient, however, bacilli had previously been found in the saliva, so that it was quite possible to expect to find them in the fæces.

The observations were as follows:—

No.	Name.	AGE.		Form.	Years afflicted.	Material examined.	Date.	No. of cover-glasses.	Result of Microscopic Examination.
		M.	F.						
1	Puniya	30	...	M	22	Fæces	27-3-91	4	1, 2, 3, 4. Quantities of bacteria. No Leprosy Bacilli.
2	Jaikishen	35	...	"	29	"	27-3-91	4	1, 2. Quantities of bacteria. (No Leprosy Bacilli. 3, 4. Numerous decolorised rods and cocci.
3	Phaganiya	32	...	A	12	"	11-4-91	2	1, 2. Swarms of bacilli and cocci, also bright oval fuchsin-spores (described by Koch). ²²
4	Gumaniya	35	...	"	19	"	11-4-91	2	1, 2. Swarms of bacteria stained blue and brightly stained oval fuchsin-spores.
5	Bishan Singh	30	...	T	10	"	13-4-91	4	1. A few Leprosy Bacilli. 2. Swarms of cocci and large bacteria stained blue, also oval fuchsin-spores. 3, 4. No Leprosy Bacilli.

Sputum.

Sputum from six lepers was examined, four cover-glasses being taken from each case. Five of the cases were mixed, and one tuberculated. All the patients had raucous voices, indicating leprosy infiltration of the larynx. It was therefore to be expected that bacilli would be found in the sputum. It appears to us that it is absolutely impossible to confuse Leprosy and Tubercular sputum. In the former case isolated bacilli are very rarely seen, but large typical cells filled with bacilli, to such an extent that it is difficult to recognize them individually, abound in advanced cases. In the absence of autopsies during the laboratory work, we are unable to speak definitely as to the existence of leprosy phthisis. Leprosy Bacilli were present in four

(²²) Koch, Mit. a. d. Kaiser. Gesundh. Bd. II, 1884, page 34.

out of the six patients, or in seventeen out of the twenty-eight specimens, as shown below:—

No.	Name.	AGE.		Form.	Years afflicted.	Material examined.	Date.	No. of cover-glasses.	Result of Microscopic Examination.
		M.	F.						
1	Harkua .	40	...	M	31	Sputum . .	15-4-91	4	1, 2, 3, 4. No bacilli.
2	Saduli .	...	38	"	10	Sputum mixed with blood.	15-4-91	4	1, 2, 3, 4. No bacilli.
3	Kunka .	...	28	"	10	Sputum . .	15-4-91	4	1, 2, 3. Clumps of Leprosy Bacilli in cells. 4. Negative.
4	Puniya .	30	...	"	22	" . .	15-4-91	4	1, 2. Clumps of Leprosy Bacilli in cells. 3, 4. Negative.
5	Fakira .	30	...	"	10	" . .	15-4-91	4	1, 2, 3, 4. Quantities of Leprosy Bacilli aggregated in cells.
6	Rahim Khan.	35	...	F	01	" . .	12-5-91	8	1, 2, 3, 4, 5, 6, 7, 8. Clusters of Leprosy Bacilli in cells.

Menstrual Discharge.

This was sent by Dr. Cook from Madras. The first specimen was from an anaesthetic leper, aged 40. It was taken on June 28, and examined on July 17, 1891. Ten cover-glasses were prepared, and all gave negative results.

The second specimen was from a patient, aged 19, suffering from mixed leprosy. It was taken on June 27, and examined on July 17, 1891. Ten cover-glasses showed shreds of epithelium, bacteria, micrococci, but no Leprosy Bacilli.

These results are similar to those obtained from vaginal mucus.

III.—DISTRIBUTION OF THE LEPROSY BACILLUS OUTSIDE THE BODY.

Little is yet known of the natural history of the Leprosy Bacillus outside the human body. Arning²¹ claims to have found it in the

(²¹) Report on Leprosy in Hawaii, 1886.

earth of a leper's grave in Hawaii, but failed to find it in mosquitoes which had sucked the blood of lepers. Kaurin²² failed to find it in earth and in the dust and air of rooms inhabited by lepers. Observations in Trinidad failed to show the bacillus in the earth of the asylum cemetery, or in salt fish, salt pork, or urhur dal (*Cytisus cajan*).²³ The attention of the Commission in India was chiefly directed to the following possible habitats of the bacillus outside the human body:—

Earth.	Fish and crustacea.
Water.	Flies.

Earth.

The occurrence of Leprosy Bacilli in earth has already been referred to in the paper on contagion. It will be sufficient to repeat here that a hundred cover-glass preparations were made from earth taken from four of the most likely sites for Leprosy Bacilli within the Almora Asylum compound. Only ten bacilli were found in all these observations, and they occurred on seven cover-glasses. Gelatine plates inoculated from this earth failed to show any colonies of Leprosy Bacilli. It will be seen from the table given below that the number of bacilli to be found in earth habitually trodden by lepers is extremely small, and it is open to doubt whether the few bacilli found were alive.

Observations on Earth at Almora Leprosy Asylum.

Source of Earth.	No. of cover-glasses examined.	No. of Leprosy Bacilli found.
1. Path in front of office . . .	25	3 on 1 cover-glass. 2 " 1 " 1 " 1 " 1 " 1 "
2. Path down hill to leper quarters .	25	1 on 1 cover-glass. 1 " 1 "
3. Path under bank where lepers sit .	25	1 " 1 "
4. Bank where lepers sit . . .	25	No bacilli. (One suspicious.)

TOTAL . . . 10 bacilli in 100 observations.

(²¹) Journal of the Leprosy Investigation Committee, No. 2, p. 63.

(²²) Report on Trinidad Leprosy Asylum, 1889, pp. 9 and 10.

Water.

The readiness with which Leprosy Bacilli can be washed out of tuberculated ulcers and detected in basins or other vessels of water has been shown in the preceding section. The object of the present inquiry is to ascertain whether these bacilli can be found distributed in larger collections of water.

For this purpose water was examined from the Almora Leper Asylum and also from the holy tank at Tarn Taran Leper Asylum. This tank is stagnant and overgrown with algæ, and if Leprosy Bacilli are found anywhere in water, they ought to be present here, for this tank is supposed to have remarkable healing properties, and lepers are constantly in the habit of bathing in the water, and swimming through it in the hope of getting rid of their disease.

An examination of fifty cover-glasses prepared from this water failed, however, to show any unequivocal Leprosy Bacilli. Four of the specimens gave several short pink rods closely resembling the bacilli sought for, but after careful and repeated examination by different members of the Commission, it was finally decided that they could not be regarded as Leprosy Bacilli.

The following table shows the observations made on water:—

Source of Water.	No. of cover-glasses.	Result of Microscopic Examination.
1. Water from tank at Almora Asylum, used for supplying bath-room.	2	1, 2. No Leprosy Bacilli.
2. Water from puddle outside spring of drinking water often visited by lepers.	2	1, 2. Debris. No Leprosy Bacilli.
3. Water from tank in which lepers bathe at Tarn Taran Asylum.	50	1 to 50. No positive Leprosy Bacilli. Four specimens showed very suspicious rods taking pink stain.

Fish and Crustacea.

A full discussion of the fish theory is given in the chapter on food in relation to leprosy. Though, as will be seen in that part of the report abundant evidence unfavourable to this theory was collected

in the Punjab, and the Asylums of Almora and Dehra Dun, still it was thought that the laboratory work ought to include the examination of as many varieties of fish and crustacea as possible. For this purpose five different varieties of nga-pi were collected while part of the Commission was travelling in Burma, and specimens of dried fish and shrimps were kindly sent from Darjeeling by Surgeon-Major O'Brien. Numerous species of dried and fresh fish, with some shrimps and crabs, were also obtained from Bombay through the kindness of Dr. J. H. Choksy, and these were supplemented with a few recent specimens of fresh-water fish from the neighbourhood of Simla.

It was considered advisable to examine fish from Darjeeling, for some members of the Commission when making enquiries in this station found to their surprise that dried fish was consumed by almost every native inhabitant. The expenditure of a trifling sum was sufficient to procure enough dried fish for a month, and this was eaten with each meal more as a condiment, like the nga-pi in Burma, than as a food.

Though leprosy is not unduly prevalent in Darjeeling, still it was thought that an examination of the article of diet in question derived from a locality presenting the unusual feature of a hill district where fish is almost universally consumed, would not be without interest. Two hundred coverglass preparations were made from five varieties of nga-pi, and nineteen species of fish and crustacea, and the material was most carefully stained and examined, but in no case could Leprosy Bacilli be found. As might have been expected, numerous bacteria and other micro-organisms were present, and it is noteworthy that these in most instances retained the pink stain. This only serves to emphasise the fact which has been remarked elsewhere in this report that the staining reaction is after all only of partial importance in diagnosing different bacilli.

The results are given in the appended short table. Unfortunately the species of the various fish and crustacea could not be determined, but this is of less importance since the results were negative.

No.	Description.	Locality.	No. of cover-glasses.	Result of Microscopic Examination.
1	Raw-eaten nga-pi	Burma	20	Negative.
2	Zayah nga-pi	"	20	" One curved stained bacillus, but not Bac. Lep.

No.	Description.	Locality.	No. of cover-glasses.	Result of Microscopic Examination.
3	Gnagye nga-pi (putrid, infested with maggots).	Bombay	20	Pink bacilli in four specimens, one in each. Numerous micrococci. No Leprosy Bacilli.
4	Gnaphayoung nga-pi.	"	20	Several bacilli, well and badly stained, some curved. No Leprosy Bacilli.
5	Gnakheo nga-pi.	"	20	A few pink bacilli, straight and curved. No Leprosy Bacilli.
6	Dried duck.	Bombay Darjeeling	5	One slightly curved pink bacillus. No Leprosy Bacilli.
7	" fish.	"	5	One or two pink bacilli.
8	" " "	"	5	Large bacilli taking pink stain.
9	" " "	"	5	A few pink bacilli.
10	" shrimps.	"	5	About a dozen large bacilli taking pink stain.
11	" Bombay duck.	Bombay.	5	Micrococci and one large curved bacillus staining pink.
12	" pomfret.	"	5	Considerable numbers of large bacilli taking pink stain.
13	" fish.	"	5	Large thick stained bacilli, not Bac. Lep.
14	" " "	"	5	Ditto ditto.
15	" " "	"	5	Plenty of large thick bacilli, long bacilli, and micrococci, all taking pink stain.
16	" " "	"	5	Ditto ditto.
17	" " "	"	5	Ditto ditto.
18	" " "	"	5	Ditto ditto.
19	" " "	"	5	Ditto ditto.
20	Dried fish.	Bombay.	5	Rods of various sizes taking pink stain. No Leprosy Bacilli.
21	" " "	"	5	Ditto ditto.
22	" " "	"	5	Ditto ditto.
23	" " "	"	5	Ditto ditto.
24	Fresh fish.	Simla.	5	Large bacilli.
25	" crabs.	Bombay.	5	Negative.

(20) In many of the samples of fish and nga-pi, stained bodies, which had a crystalline appearance were seen. Possibly these are crystals of fatty acid and similar to the pseudo-bacilli described by Celli and Guarnieri. The paper of these authors is in *Accadem. dei Lincei*, June 1883.

Flies.

The part played by flies in the spread of certain diseases has been recognised for some time, and it seems reasonable to suppose that they may be capable of conveying the Leprosy Bacillus. An opportunity of putting this to the test occurred at the Almora Asylum. Three lepers were caused to sit on the ground and expose the tuberculated ulcers of their feet. These were soon visited in large number by common house flies, which settled on the ulcers, and fed on the discharges. Several of these flies were caught on the ulcers, their abdomens were opened and cover-glass preparations were made of the intestine and contents. No Leprosy Bacilli could be detected in the flies, though the discharge on which they were feeding was shown in two of the lepers to be rich in Leprosy Bacilli. Indeed, the third leper had been proved to have numerous bacilli in other parts of his body, though by an oversight these particular ulcers were not examined.

Only ten cover-glasses were prepared from ten flies, and it is quite possible that a more extended series of observations might show Leprosy Bacilli. Still considering the immense quantities of Leprosy Bacilli found in the discharge from these tuberculated ulcers, it is strange that they are not more readily discoverable in flies which have fed on these discharges.

A short table follows:—

No.	Name.	Age.		Form.	Years afflicted.	On what flies had fed.	No. of flies.	No. of cover-glasses.	Result of Microscopic Examination.
		M.	F.						
1	Puniya	30	...	M	22	Discharge from tuberculated ulcer of foot	7	7	1-7. No Leprosy Bacilli.
2	Pakira	30	...	"	10	Ditto ditto	2	2	1, 2. Ditto.
3	Bishan Singh	30	...	F	10	Ditto ditto	1	1	1. Ditto.

IV.—VACCINATION.

Of late years much attention has been directed to the possibility of infecting persons with leprosy through vaccination. Gairdner in

1887 published a case, in which a doctor in a tropical island vaccinated his own child from a native child who afterwards became leprosy. Another white child was vaccinated from the doctor's child, and both these children also developed leprosy. The case excited much interest, and many people assumed that it proved the possible transmission of leprosy by vaccination. A perusal of the case, however, shows that the details are very few and insufficient to establish any conclusion. Moreover, leprosy was endemic in the island, so that the possibility of infection from outside sources was always present.

Direct experiments bearing on the subject have not been wanting. Arning in Hawaii vaccinated lepers and examined the lymph. He found bacilli in the vesicles raised in cases of extensive tuberculated leprosy in which the skin contained bacilli. In cases of pure anæsthetic leprosy he found no bacilli.

A series of observations made in the Trinidad Asylum on vesicles raised on tuberculated, anæsthetic, and mixed lepers failed to show any Leprosy Bacilli, and animals vaccinated with lymph from these vesicles did not develop leprosy.

Daubler's observations²⁷ refer to two women on Robben Island,²⁸ aged 15 and 35 years, respectively, both of whom he believed contracted leprosy through vaccination. Both individuals were vaccinated with the lymph obtained from a patient who subsequently died of tubercular leprosy. In the first patient the site of inoculation swelled a few days after the puncture and had a brown hue, but no true vaccine vesicle formed. Subsequently after the swelling had subsided, fever and rigors occurred, and by the eighteenth week swelling and discoloring of the right frontal eminence was seen. The second patient, two months after the vaccination, showed the typical leonine aspect of a tuberculated leper. These cases are frequently quoted, but Arning's experiments, which are in complete accordance with the clinical experience of all observers, do not permit of the belief that such an essentially chronic disease as leprosy is produced so soon after inoculation.

Quite recently Dr. Simpson has vaccinated lepers in Calcutta, and claims to have found Leprosy Bacilli in the vaccine lymph.

In view of these conflicting statements, it seemed that further and

(27) Daubler, Ueber Lepra und deren Contagiosität, Monat für prakt. Dermat. Bd. VIII, 1882, p. 123. Abstract in Baumgarten's Jahresbericht, 1889, p. 243.

(28) An island in Table Bay where the lepers are removed from Cape Town.

more numerous observations on vaccine lymph taken from lepers would be of value.

A suitable opportunity occurred at the Almora Asylum, where all the lepers who were well enough were vaccinated, amounting to some eighty-seven in all.

Of these forty (twenty-one males, nineteen females) developed vesicles, which were examined. Of the forty cases, thirty-four were anæsthetic, five mixed, and one was tuberculated.

The condition of the skin where vaccinated was as follows:—

In 14 cases it was normal.

" 13 " there was an anæsthetic patch.

" 12 " sensation was diminished.

" 1 case it was tuberculated.

The condition of the vesicle was as follows:—

In 31 cases normal.

" 2 " purulent.

" 2 " purulent and mixed with blood.

" 1 case normal one arm and purulent on the other.

" 1 " normal, but mixed with blood in taking.

" 1 " immature.

" 1 " immature and mixed with blood in taking.

" 1 " immature and the crust taken.

Crusts also were taken from two vesicles which had been normal.

Ninety-three cover-glasses were prepared and stained with Ziehl's solution, passed through acid and then treated with methyl-blue. In no case were Leprosy Bacilli found. Suspicious-looking rods taking fuchsin were found in one case in vesicles raised over tuberculated ears, and in another case in vesicles over anæsthetic patches.

But even if these cases be considered as positive, and the utmost value allowed to them, they would have little or no importance in the question at issue, for no vaccinator would be likely to vaccinate a leper over a tubercle or anæsthetic patch, and use the lymph obtained from such vesicles for vaccinating healthy individuals.

It is therefore our opinion that assuming the presence of the bacillus to be necessary to produce leprosy, this series of observations, which is the most extensive yet made, conclusively shows that no danger need be apprehended from the vaccine lymph of even an actual leper, provided he has been vaccinated on normal skin. *A fortiori*, therefore, there is no danger of transmitting leprosy by using as a vaccinifer a child born of a family in which leprosy exists provided reasonable care be taken.

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The following table gives a detailed account of the observations made in Almora :—

No.	Name.	ALMORA ASYLUM.				VACCINATION.		Date of vaccination.	Date of taking lymph.	No. of cover-glasses.	Result of Microscopic Examination.
		AGE.	Form.	Years afflicted.	Condition of skin where vaccinated.	Condition of vesicle.					
		M.	F.								
1	Amarna.	25		M	13	Normal	R. arm purulent.	4-3-91	22-3-91	2	1. Numerous diplococci stained blue. 2. Numerous diplococci stained blue; also few small rods stained blue.
2	"	25		"	13	"	L. arm normal.	4-3-91	22-3-91	4	1. Few small badly stained rods and diplococci. 2, 3, 4. Negative.
3	Bachi	25		A	20	Sensation diminished.	Normal, but the lymph was mixed with blood in taking.	19-3-91	25-3-91	2	1. Few pale rods; no Leprosy Bacilli. 2. Debris and rods; no Leprosy Bacilli.
4	Mongolia	26		"	15	Anæsthetic patch.	Normal	19-3-91	25-3-91	4	1. No bacilli. 2. Few small rods stained blue. 3. Few small rods not stained. 4. Debris and rods; no Leprosy Bacilli.
5	Teliga	35		M	20	"	"	19-3-91	25-3-91	2	1. Three badly stained rods; no Leprosy Bacilli. 2. No Leprosy Bacilli.
6	Jitna	30		"	3	"	R. arm normal.	21-3-91	27-3-91	2	1. Suspicious rods taking fuchsin. 2. Suspicious rods taking fuchsin.
7	Jitna	30		"	3	Anæsthetic patch.	L. arm normal.	21-3-91	27-3-91	2	1. Suspicious rods and cocci taking fuchsin. 2. Suspicious rods and cocci taking fuchsin.
8	Jogia	45		A	33	Sensation diminished.	Normal	24-3-91	30-3-91	2	1. Small blue rods, epithelial cells, with nuclei taking methyl-blue readily. 2. Small blue rods; epithelial cells, with nuclei taking methyl-blue readily.

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No.	Name.	ALMORA ASYLUM.				VACCINATION.		Date of vaccination.	Date of taking lymph.	No. of cover-glasses.	Result of Microscopic Examination.
		AGE.	Form.	Years afflicted.	Condition of skin where vaccinated.	Condition of vesicle.					
		M.	F.								
9	Rhagia	35		A	21	Normal	Normal	24-3-91	30-3-91	2	1. No Leprosy Bacilli: epithelial cells with nuclei. 2. Epithelial debris, lymph cells, rods, and micrococci. No Leprosy Bacilli.
10	Gumyana	35		"	19	Sensation diminished.	"	24-3-91	30-3-91	1	1. Wholly negative.
11	Jaikishen	35		M	29	Tuberculated (ear).	"	25-3-91	1-4-91	2	1. One or two bacilli taking fuchsin. 2. Debris: no bacilli.
12	"			"	29	"	"	25-3-91	1-4-91	2	1. One or two badly stained bacilli. 2. Debris: no bacilli.
13	Chandra	30		"	11	Normal	"	28-3-91	1-4-91	2	1. Few small blue cocci; no bacilli. 2. Debris: no bacilli.
14	Bhaisaki	36		A	20	"	"	28-3-91	1-4-91	2	1. Debris: no bacilli. 2. Debris: no bacilli.
15	Heroli	32		"	15	Sensation diminished.	"	28-3-91	3-4-91	2	1. Debris: no bacilli. 2. Debris: no bacilli.
16	Deluli	45		"	12	Normal	"	28-3-91	6-4-91	2	1. No Leprosy Bacilli. 2. No Leprosy Bacilli.
17	Jaikishen	35		M	29	Tuberculated (ear).	Crust from broken vesicle.	25-3-91	6-4-91	2	1. No bacilli. 2. Few bacilli stained blue: no Leprosy Bacilli.
18	Gumyana	35		A	19	Sensation diminished.	Crust from broken vesicle.	24-3-91	6-4-91	2	1. Numerous cocci stained blue: no Leprosy Bacilli. 2. Numerous cocci stained blue: no Leprosy Bacilli.

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No.	Name.	ALMORA ASYLUM.				VACCINATION.	Date of vaccination.	Date of taking lymph.	No. of cover-glasses.	Result of Microscopic Examination.
		Age.	Sex.	Form.	Years afflicted.					
19	Gulavi	50	A	17	Anæsthetic patch	Normal	30-3-91	4-4-91	2	1. Unstained bacilli; no Leprosy Bacilli. 2. Debris: no Leprosy Bacilli.
20	Bhusi	50	"	35	Normal	"	30-3-91	4-4-91	2	1. Blue rods: no Leprosy Bacilli. 2. Numerous cocci and diplococci: no Leprosy Bacilli.
21	Bhaguli	26	"	10	"	"	30-3-91	4-4-91	2	1. Few blue rods: no Leprosy Bacilli. 2. Few blue rods: no Leprosy Bacilli.
22	Ganguli	50	"	22	Sensation diminished.	"	30-3-91	6-4-91	2	1. Group of vaccine cocci stained blue: no Leprosy Bacilli. 2. Few bacilli stained blue: no Leprosy Bacilli.
23	Dikvi	50	"	8	Anæsthetic patch.	"	31-3-91	6-4-91	2	1. Short thick bacilli taking pink stain: no Leprosy Bacilli. 2. No bacilli.
24	Bachali	40	"	5	"	"	31-3-91	6-4-91	2	1. Debris: no Leprosy Bacilli. 2. Debris: no Leprosy Bacilli.
25	Parmati	40	"	34	Sensation diminished.	"	30-3-91	6-4-91	2	1. Debris: no bacilli. 2. Few bacilli taking blue stain: no Leprosy Bacilli.
26	Naduli	50	"	20	"	"	30-3-91	6-4-91	2	1. Numerous cocci stained blue. 2. Numerous leucocytes: no Leprosy Bacilli.
27	Gopuli	30	"	10	"	"	30-3-91	6-4-91	2	1. Debris: no bacilli. 2. Few cocci; no bacilli.
28	Khimuli	50	"	20	Sensation diminished.	"	30-3-91	6-4-91	2	1. Rods of various sizes: no Leprosy Bacilli. 2. Rods of various sizes: no Leprosy Bacilli.

Appendix I.

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No.	Name.	ALMORA ASYLUM.				VACCINATION.	Date of vaccination.	Date of taking lymph.	No. of cover-glasses.	Result of Microscopic Examination.
		Age.	Sex.	Form.	Years afflicted.					
29	Himatna	60	A	12	Sensation diminished.	Normal	1-4-91	7-4-91	2	1. Debris: no Leprosy Bacilli. 2. Debris: no Leprosy Bacilli.
30	Jasuli	41	"	19	Normal	Purulent and mixed with blood.	30-3-91	7-4-91	2	1. Debris: no bacilli. 2. Cocci and diplococci: no bacilli.
31	Dhania	25	"	4	Anæsthetic patch.	Normal	1-4-91	7-4-91	2	1. Cocci and bacilli stained blue: no Leprosy Bacilli. 2. Cocci and bacilli stained blue: no Leprosy Bacilli.
32	Karakna	25	"	13	Sensation diminished.	Imperfectly developed.	3-4-91	10-4-91	2	1. Debris: no bacilli. 2. Debris: no bacilli.
33	Khimuli	18	"	13	Normal	Purulent	3-4-91	10-4-91	2	1. Pus cells and developing fibrous tissue: no bacilli. 2. Pus cells: no bacilli.
34	Partima	55	T	10	"	Normal	5-4-91	11-4-91	2	1. Bacilli stained blue and shreds of tissue. 2. Bacilli stained blue and shreds of tissue.
35	Motiya	20	A	10	"	"	8-4-91	13-4-91	2	1. Numerous cocci: no Leprosy Bacilli. 2. No Leprosy Bacilli.
36	Kamalua	40	"	28	Sensation diminished.	"	8-4-91	13-4-91	2	1. Debris: no bacilli. 2. Debris: no bacilli.
37	Budhia	32	"	1	Anæsthetic patch.	Purulent and mixed with blood.	8-4-91	13-4-91	2	1. Debris: no bacilli. 2. Debris: no bacilli.
38	Telegu	60	"	30	"	Immature vesicle and mixed with blood.	9-4-91	13-4-91	2	1. Cocci and bacteria: no Leprosy Bacilli. 2. Cocci and bacteria: no Leprosy Bacilli.
39	Sundarsai	40	"	7	Normal	Normal	9-4-91	13-4-91	2	1. Cocci: no bacilli. 2. Cocci: no bacilli.
40	Gujia	45	"	17	"	"	8-4-91	13-4-91	2	1. Debris: no bacilli. 2. Debris: no bacilli.

No.	Name.	ALMORA ASYLUM.			Condition of skin where vaccinated.	VACCINATION.	Condition of vesicle.	Date of vaccination.	Date of taking lymph.	No. of cover glasses.	Result of Microscopic Examination.
		Age.	Sex.	Years afflicted.							
41	Kalangit	28	A	3	Normal	Normal	Normal	8-4-91	13-4-91	2	1. Bacteria: no Leprosy Bacilli. 2. Bacteria: no Leprosy Bacilli.
42	Gumani	28	"	20	Anæsthetic patch.	Purulent	Purulent	10-4-91	13-4-91	2	1. Pus cells: no Leprosy Bacilli. 2. Pus cells: no Leprosy Bacilli.
43	Harna	34	"	30	"	Normal	Normal	8-4-91	13-4-91	2	1. Debris: no bacilli. 2. Debris: no bacilli.
44	Maina	60	"	30	"	"	"	9-4-91	14-4-91	2	1. Debris: no bacilli. 2. Debris: no bacilli.
45	Dhanra	30	"	12	"	Crust of imperfect vesicle.	Crust of imperfect vesicle.	9-4-91	14-4-91	2	1. Large rods taking like stain: no Leprosy Bacilli. 2. Debris: no bacilli.

V.—CULTIVATION EXPERIMENTS.²²

Hansen, in his original paper, described both rod-formed bodies (*Bacillus Lepre*) in tubercles, and jointed threads obtained in specimens of blood which, when kept in a moist chamber, developed into a mycelial growth, as probable specific microscopical features of true leprosy. He also figured these granular mycelial masses, and spoke of them as a culture, but it is almost certain that this must be looked upon as a contamination of the specimen, and since the *Bacillus Lepre* never occurs in blood, this growth could not have been a development of these. It is clear also that Hansen himself did not regard the mycelium in this light.

The cultivation experiments of Neisser²³ are the earliest, and the details may be given in his own words.

1. An unbroken tubercle was thoroughly cleansed with alcohol, then removed with every possible precaution against foreign infection, and finely divided up with needles made sterile in a flame. Particles of this broken up material were employed in the following three culture methods:—

(a) With blood serum in hollow-ground microscope slides. The hollow spaces were very capacious and contained much air.

⁽²²⁾ The references available in India for this section are exceedingly few.
⁽²³⁾ Virchow's Archiv. 1881, 1886.

(b) In test tubes, carefully cleansed by heat and acids, which were partly filled with blood serum or with alkaline sterilized flesh-extract-solution.

(c) Under cover-glasses with blood serum, in a space where evaporation was checked. All these preparations were kept permanently in a warm chamber at 35°–39°C.

2. Cultivations from pus and juice of leprosy nodule which were protected in capillary glass tubes from accidental fouling. The tubes contained much air and were sealed.

Neisser describes three bacilli: first, movable rods which are perfectly free from distortion of any kind; second, motile rods with a minute ball-like swelling at one or both extremities or in the middle; these rods are somewhat longer than the first variety and frequently sharply bent; third, bacilli which are characterised by being distinctly longer and broader than either the first or second kind; each of these rods contains one to four clear unstained spaces (vacuolation). It is possible, according to this observer, that the breaking up of the rod into granules (*kokkothrix*) which lie in a row adhering together because of the hull which invests the bacillus, is a retrogressive metamorphosis, and that the bacilli of the second and third kinds exhibit veritable spore-formation. Lastly, both in cultures and in microscopical preparations of leprosy tubercles which, after experimental introduction, had been encapsuled in the peritoneal cavity, the bacilli grew into a thread occasionally four times the normal length, but in these no sign of anything which could be called a spore-formation was evident.

From a careful examination of Neisser's figures, especially 1 and 10, it appears not unlikely that, as he claims, a veritable culture was obtained. Further, the three kinds of bacilli described by him are to be seen in juice from a leper tubercle. Of the actual existence of two—the first and third kinds—there can be no question, but the relation of these to each other is not so clear; both stain excellently with the Koch-Ehrlich method and resist decolorization with acids; and also Gram's method clearly defines both of them, especially the latter. Neisser's first kind is the normal *Bacillus Lepre*; the second we believe to be possibly a distortion, for a swelling upon a rod can easily be caused to appear and disappear, as the bacillus slowly turns under the cover-glass; and the appearance seen is figured on Plate III, Fig. VIII; the third form, as far as we can judge from his Figs. 7 and 13, we have frequently seen and have also, we believe, cultivated. Whether it is a bacillus possessing pathogenic power it is impossible to say. This form, which it is very probable is the same

as that described by Neisser, we shall speak of as the vacuolated bacillus. In a later paper Neisser,³¹ as the result of extended observations, inclines to the view that the vacuoles, or spaces in the bacillus, are veritable spores, though in no instance has he seen an isolated spore. The ball-like swelling in the second kind he does not regard as a spore-formation. He also confirms the presence of the hull of the bacillus, stating that it can easily be seen after staining a preparation with watery dye. The presence of this hull is botanically of interest; it occurs also in the *Bacillus Tuberculosis*,³² *Pneumococcus*,³³ and several other forms.

Further culture experiments by Neisser consisted in using solid blood serum and hard-boiled fowl or duck eggs as a nutrient medium, and minute pieces of excised tubercle, or blood from a tubercle, as material for inoculation. The culture was maintained at a temperature of 37°—38°C. The growth was exceedingly slow. Cultivation in generations was not successful. Specimens from detached bacillary islets on the medium yielded what the author held to be a genuine cultivation of the *Bacillus Lepræ*.

Hansen³⁴ in 1882 described a culture on serum of bacilli which were motile. He used methylene-blue as a stain, but according to Neisser this will not even tinge the genuine *Bacillus Lepræ*. This is not a strong argument against Hansen's culture, for in our hands methyl-blue stains the *Bacillus Lepræ*, though great differences exist in the samples of this dye, so that the discordant results of various observers are conceivable.

It is impossible to be quite certain that a veritable cultivation of the *Bacillus Lepræ* was obtained by Neisser. On Plate XII,³⁵ Figs. 1, 5, 6, and especially 10, have the appearance of true cultures, but when it is considered that this observer wholly failed to cultivate the bacillus in generations, an actual multiplication in fluids which probably did occur is all that can be conceded.

Manson,³⁶ some years before Hansen had discovered the *Bacillus Lepræ*, attempted by incubation of leper juice to discover the then unknown germ. Sealed capillary tubes were inserted into eggs which were placed under a hen. Beyond the development of streptococci, both free and in the zoogloea state, these experiments gave wholly negative results.

(³¹) Virchow's Archiv. 1886.

(³²) Lutz and Unna. Dermatol. Studien Heft I. 1886.

(³³) Friedländer. Fortschr. d. Med. Bd. III, 1885.

(³⁴) Virchow's Archiv. 1881.

(³⁵) Journal of the Leprosy Investigation Committee, No. 1, p. 40.

Arning³⁶ states "that there is no difficulty whatever in growing the *Leprosy Bacillus*, by simply allowing pieces of leprosy tissue to macerate in ordinary water, at ordinary temperatures, giving but sufficient time; but the resulting growths are not pure cultures in a strict sense."

The introduction by Koch of solid nutrient media has, to a large extent, caused nearly all observers who have attempted to cultivate the *Bacillus Lepræ* to abandon cultivation in fluid media which in the hands of Pasteur had led to many discoveries. In the history of the attempted cultivation of the specific bacillus of leprosy, the great majority of experiments have consisted in the removal of a piece of leprosy tubercle and the direct implantation of this upon a solid nutrient surface, such as agar, glycerin agar, or solidified serum.³⁷ The successful growth of *Bacillus Tuberculosis* by this method is by no means easy, and uniformly negative results with the *Bacillus Lepræ* have been obtained by the vast majority of observers.³⁸ Quite recently Sheridan Delépine and Slater³⁹ record numerous attempts to cultivate the bacillus, which were made independently at two different periods during the life of the patient. On both occasions the results were negative. The latter observer two years previously had attempted identical cultivation experiments.

In 1887⁴⁰ Bordoni-Uffreduzzi described at length his culture-experiments with the *Bacillus Lepræ*. He was as unsuccessful as previous observers in the direct implantation of a leprosy nodule on to a solid nutrient medium. The chief result of such a proceeding was a growth of *Streptococcus Pyogenes*. He considered that the *Leprosy Bacilli* which abound in leprosy nodules are enclosed in cells, and probably are not alive, though, if the view of Unna and Kühne be accepted, the bacillary heaps lie outside the cells. In the marrow of bones of a dead leper, the Italian observer found free bacilli, and from this material he raised cultivations of the *Bacillus Lepræ* on peptone-salt, glycerine-serum; it grows also upon glycerine-agar. However, the bone-marrow has been examined by Kaurin⁴¹ in many cases, and he never succeeded in finding the *Bacillus Lepræ*. It does not appear that many observations on bone-marrow have been made, but at any rate in the Haversian canals and spaces of the

(³⁶) Journal of the Leprosy Investigation Committee, No. 2, p. 117.

(³⁷) Fraenkel and Franke repeatedly failed to cultivate the *Xerosis Bacillus* in this manner by direct implantation on solid media. Schreiber, however, succeeded in this direction.

(³⁸) Among others cf. Trinidad Leper Asylum Reports, 1888.

(³⁹) British Medical Journal, May 23rd, 1891, page 1127.

(⁴⁰) Zeitschrift für Hygiene, Vol. III, page 178. This important paper was unfortunately not available in India.

(⁴¹) Journal of the Leprosy Investigation Committee, Vol. 2, p. 68.

bones of the little finger, which presented typical mutilation, masses of bacilli, both discrete, and lodged within undoubted lepra cells, have been found by Delépine and Slater.⁴¹ Sawitschenko⁴² has also worked out the histology of bone-leprosis.

Bordoni-Uffreduzzi describes the cultivated bacillus on peptone-glycerine serum at a temperature of 35°—37°C. as a light-yellow tænia-form stripe with irregular edges along the needle-track. The serum is never liquefied, and no growth ever occurs in the condensation water. On glycerine-agar a similar culture develops if a great quantity of bacillary material be streaked upon the nutrient surface. If a smaller amount be streaked, isolated lens formed colonies with jagged edges and of varying size develop. On glycerine-agar plates, both on the surface and deeply in the medium, colonies may be seen with a power of 100 diameters, which are grey, net-like growths with irregular edges. It is evident that this growth cannot be confounded with cultures of *Bacillus Tuberculosis*. The isolated bacilli in form and measurement resemble those of the tissues, but a striking peculiarity is the frequent occurrence, at one or both ends of a bacillus, of a swelling in which an arthrospore may be seen. This appearance may also be recognised in the tissues, but it is an open question whether this does not represent an involution-form. Isolated spores, or the development of a rod from such an arthrospore, have not been observed. The bacillus is quite immotile. The tinctorial behaviour of the cultivated *Bacillus Lepre* is characterised, firstly, by remaining absolutely unstained by alkaline methyl-blue,⁴³ in which it resembles the bacillus of the tissues, and secondly, by staining with much greater difficulty in Ehrlich's fuchsin, indeed, with about the same facility as the *Bacillus Tuberculosis* does. The *Bacillus Lepre* of the tissues, however, stains much more readily than the latter. In a great number of experiments on rabbits and other animals, Bordoni-Uffreduzzi wholly failed to establish the pathogenic nature of his cultivation.

Roux, Nord, Chantemesse and Cornil⁴⁴ have failed to confirm the above cultivation experiments, but Gianturco⁴⁵ has succeeded in obtaining a culture which Bordoni-Uffreduzzi admits is absolutely

(42) Loc. cit.

(43) Sawitschenko über Osteomyelitis Leprosa. Centralblatt. f. Bact. und Parasitenkunde Bd. V., 1889. According to Sawitschenko the vacuoles in lepra cells contain a liquid which is secreted by the bacilli. The absorption of bones proceeds from lepra clusters in the bone-marrow and in the dilated Haversian canals.

(44) Koch and Wesener have stained *Bacillus Lepre*, and this can be confirmed with great ease.

(45) Extr. du Bulletin de l'Académie de Médecine. Séance du 19th Juin, 1888.

(46) Abstract in Baumgarten's Jahresbericht, Vol. II, 1889.

identical with his own. At a temperature of 37° C., after seven days a colony is developed of feebly motile bacilli, which are more slender when grown on glycerine-blood-serum than when on glycerine-agar. The bacilli also possess terminal swellings (arthrospores). Both Campana⁴⁷ and Katz⁴⁸ using every precaution, have failed to cultivate the *Bacillus Lepre*. The former observer, in the course of two years, made about five hundred experiments and employed various nutrient media and material from leprous tubercle. In consequence of the total failure of these experiments he has thrown doubt on the genuineness of the culture obtained by Bordoni-Uffreduzzi.

Extensive experiments which were made in Trinidad, with total want of success, and consisting in the direct implantation of the centre of a non-ulcerated leprous tubercle, taken with every possible precaution, upon a nutrient solid medium, were repeated in India with similar result. No culture was formed, but a staphylococcus growth spread very slowly from the piece of tissue, and by the end of ten weeks the implanted piece was obscured by this growth.

The following methods were adopted in our experiments:—

1. It had been ascertained that in blisters raised over unbroken leprous tubercles, specific bacilli were frequently found. It is also well known that the pigment particles in tattoo-marks do not pass into such a fluid. It was therefore hoped that by this means a separation could be effected between the living and dead bacilli within the tubercle. Serum from blisters over the normal skin of the back of a leper was received into sterile vaccine capillary tubes, and a small quantity of the fluid of a blister raised over a tubercle was added to this. The tube, which had an air-space for about one-third of its length, was then sealed and maintained at the temperature of the body.

2. Pieces of the centre of a leprous tubercle, removed with all possible precautions, were introduced into bouillon, and maintained at the temperature of the room, which during the day averaged 27°C.

3. An unbroken tubercle was thoroughly cleanse with carbolic soap and perchloride solution. A deep puncture with a sterile needle was made into the tubercle, and perfectly clear leper juice was expressed. This was received into sterile pieces of capillary tube, about half an inch long, and the tube and contents at once dropped into bouillon. This was maintained at the temperature of the room.

In all the above instances microscopical examination showed that

(47) Abstract in Baumgarten's Jahresbericht, Vol. III, 1889.

(48) Abstract in Baumgarten's Jahresbericht, Vol. III.

the material used as the source of cultures contained Leprosy Bacilli. The results of these three methods will now be given in detail.

From what has been previously mentioned, it would appear that the direct implantation of leprosy material upon solid nutrient media gives absolutely negative results. Among the causes of this it may be suggested that the *Bacillus Lepræ*, like the bacillus of malignant edema,⁴⁹ is exquisitely anaerobic, or may be incapable of becoming a facultative saprophyte, or that in the preparation of the piece of leprosy tissue, the hot knives used to make the section cause the formation of a layer of coagulated material, through which the bacilli cannot make their way, or, lastly, because the tissue contains for the most part, only dead bacilli. The last conjecture appears most probable, since the others admit of direct experiment.

If a section of skin be made through a leprosy tubercle the bacilli are found in quantities, and fluid expressed from the neoplasm abounds in bacilli. The epidermis from the corneous to the pigmentary layer in unbroken tubercles is wholly free from bacilli, while the cutis and subcutaneous tissue is crowded with them. A blister raised over a tubercle contains a few leucocytes and at times bacilli. In some cases these latter are absent. We believed that the majority of these bacilli were alive and capable of being cultivated.

Cultivation Experiments with Blister Fluid.

Blisters were raised over tubercles on the ears, face and wrists, and at the same time over normal skin between the shoulder blades. After avoiding all sources of fouling, sterilised vaccine capillary tubes were charged with a minute quantity of fluid from a blister over a tubercle, and also with seven or eight times the quantity of fluid from a blister over the normal skin of the same leper. They were then sealed. Each tube also contained air for about one-third of its length. The dates of these experiments ranged from March 31st to May 13th. In all cases samples of the blisters, both over the tubercles and on the back, were examined for the bacillus. Being at this time without an incubator, the tubes were packed with a small thermometer in a cylindrical box and carried in the axilla, a proceeding adopted by Spallanzani in the last century when studying the action of the digestive juices on food. A month later these tubes were examined and resealed, and in several cultures were seen. A tube containing a culture was now sterilised as far as was possible without injury to the

(⁴⁹) Discovered by Koch and first cultivated in bouillon with absence of oxygen by Pasteur.

contents, broken at both ends, and dropped into fluid glycerine-bouillon and shaken carefully. In this bouillon a culture of bacilli, which we believed to be Leprosy Bacilli for the reasons given below, developed, a slight turbidity occurred about the third day and a pellicle subsequently formed on the surface, so that a good tenacious scum was produced by the twelfth day. In the mode of formation of this pellicle, minute particles appeared on the surface of the bouillon, which daily increasing in number, joined together, so that the whole growth could be seen steadily advancing from the centre to the periphery. In some cases, a fortnight later this pellicle sank partly in the fluid. From such original bouillon cultures, gelatine and glycerine-agar media were inoculated. The growth liquefied the gelatine and grew also well on agar. Generations up to the sixth were carried on at Simla from April 26th to August 20th, 1891. Out of about twenty-five experiments (some of which failed to give any culture in the capillary tube), the following may be given as examples:—

1. Blister fluid over the tubercle of Puniya, and fluid taken from a blister over normal skin of the back of same leper, mixed in a sealed capillary tube with an air space. Taken on April 14th, 1891, kept at body temperature until May 2nd, when part of the contents was examined. Leprosy Bacilli brightly stained were found. The tube was resealed, and on May 14th this was broken and dropped into bouillon. The tubes were kept at a temperature of 26°C. On May 25th a minute white speck was seen floating on the surface of the liquid. Two days later, a thin film, most dense in the centre, almost covered the surface of the liquid. A small amount of this film subsided to the bottom of the test tube. Microscopic examination showed rods which were very feebly motile; they did not change position, but slowly bent and returned to the straight condition. Most of the bacilli were in clusters. In measurement and shape these were undistinguishable from Leprosy Bacilli. Specimens stained in warm Ziehl's solution for twenty minutes and decolorised in 25 per cent. nitric acid, were stained pink. No beaded appearance was seen. On May 28th two specimens of this growth were stained for twenty-four hours in Ziehl's solution, decolorised and found to show quantities of brightly stained bacilli, separate and in clusters. On May 29th the bouillon was covered with a coherent pellicle. By June 1st the pellicle had in great part subsided en masse to the bottom of the tube.

Cultures in glycerine-bouillon, glycerine-gelatine, and glycerine-agar were made from this original growth and carried on for several generations. The growth in gelatine shows on the second day a minute white speck on the surface, and subsequently a liquefaction takes place along the needle track. This appearance is represented in Fig. 2, Plate II. Subsequently two strata of growth form, separated by a clear liquid space. The microscopical appearance of these strata is identical as far as staining with the Ziehl method is concerned; both consist of bright red rods, but those from the upper stratum are slightly thicker than those from the lower one.

The growth on agar presents an irregular outline at the edge of the needle stroke, and this extends rather rapidly, so that a great part of the surface is covered. Its subsequent spread is, however, exceedingly slow.

All these growths in bouillon, gelatine and agar were pure and undoubtedly identical, and the bacilli stained excellently, and resisted decolorisation with 10 per cent., 15 per cent. and 20 per cent. nitric acid. This resistance varied at different periods of growth, being greatest in the early stages. Subsequent generations, though retaining the shape of the original, did not resist the action of the acid so well, but still stained to some extent. The individual bacilli were shorter and slightly thicker than those obtained in alcohol hardened leprosy tubercles. They also had a distinct tendency to aggregate into clusters and lines.

This series of experiments was repeated and the details were as follows:—

2. Expressed tubercle juice of Bishan Singh, and fluid from blister over sound skin of the same leper, was collected in a sealed capillary tube on April 14th; examined on May 6th and 7th, stained bacilli were found in strings and in groups. No admixture of other bacilli found. A bouillon tube was inoculated and a growth commenced. This culture however fouled a week later.

3. Expressed tubercle juice of Bishan Singh, and fluid from a blister over the sound skin of the back of the same leper, was taken on April 14th; examined on May 8th, numbers of stained bacilli, which had the appearance of a culture, were found. No other bacteria present. The tube was resealed and again examined on May 14th; no bacilli were found. A bouillon tube, inoculated on May 14th, was the commencement of a series similar to Series I.

Cultivation experiments with Excised Tubercle in Bouillon.

Rahim Khan, a Muhammadan, formerly resident in Thibet, has very marked tubercular leprosy. The disease commenced two and a half years ago, and the patient is at present in the full height of the disease; the lobes of both ears are enormously pendulous and thickened. The whole aspect of the man indicates that he is extensively diseased. The uvula is destroyed and there is extensive ulceration of the fauces and the raucous voice indicative of laryngeal trouble. His saliva and sputum abound in nests of Leprosy Bacilli. It was determined in this case (and the results of the treatment were a great improvement in the health of the patient) to excise the tuberculated masses in the ears. Accordingly, on May 22nd, 1891, the whole lobe of the left ear was excised with all antiseptic precaution. The mass was placed in a sterile plate, and with sterilised knives, one cut being made with only one knife, pieces from the centre were placed in bouillon, gelatine and on glycerine-agar. Nine tubes were prepared in this way, seven being bouillon. The pieces of tissue abounded in bacilli. From none of these experiments were Leprosy Bacilli obtained. The growth on agar about a

week later showed streptococcus chains, and the gelatine presented the same growth; the other tubes, with one exception, became turbid and foul, but in this isolated instance a bacillus shown in Fig. 7, Plate III, was obtained, and successive pure cultivations raised upon gelatine agar and bouillon. The bacillus, which was certainly obtained from the tissues, and was never seen in numerous accidental foulings, we believe is probably the third variety figured by Neisser. It stains exactly like the bacillus of the tissues with Ziehl's solution, and resists powerful decolorisation with acids. Gram's method makes its structure very evident, and it stains also by the method employed by Giacomi for the Syphilis Bacillus (?) of Lustgarten. Aqueous methyl-blue and most of the common aniline dyes stain this vacuolated bacillus perfectly.

This vacuolated bacillus is absolutely immotile even in the early stage. At this period a rod-shaped organism, in length and breadth exceeding the typical *Bacillus Lepre*, but smaller than *Bacillus Subtilis*, is seen aggregated into clusters and now shows no trace of vacuolation. This subsequently occurs when the culture is about one week old, and one to four clear unstained spaces are to be seen in the rod, which is slightly increased in length. Bacilli, shorter than *Bacillus Lepre*, with only one ovoid space, are also to be seen, and occasionally a club-shaped form with a terminal space. At all periods of growth this bacillus stains admirably by the methods employed as diagnostic of the *Bacillus Lepre* of the tissues. We do not believe these clear spaces are spores. In no instance were isolated spores seen. The study of the bacillus in hollow ground glass slides did not throw any light on this question.

The growth of this vacuolated bacillus in bouillon is very like that formerly described for the bacillus obtained by the blister method. In gelatine the appearance is, however, so characteristic that it was easily possible to at once detect the culture. A speck growing to a white disc appears after twenty-four hours, the needle track at the same time commencing to form a stocking-like liquefaction in the gelatine. At the end of sixty hours a tenacious pellicle forms on the surface of the gelatine, and a flocculent deposit settles down to the lower part of the liquefied stocking-like tract. Subsequently the pellicle becomes still denser, and by the end of ten days the growth has almost ceased, all the gelatine is fluid, and a flocculent loose deposit occurs at the bottom of the tube. The growth on glycerine-agar is much slower, and there is nothing very typical about this.

On June 20th the lobe of the right ear of the same leper was

excised, and with all precautions, pieces of tuberculated tissue were placed in six tubes of bouillon and two of gelatine. The cultures were kept at the room temperature, which averaged 25°C. On the eleventh day in two of the bouillon tubes distinct turbidity was noticed, and both tubes showed bacilli closely resembling the Leprosy Bacilli of the tissues in shape and staining reactions. No other bacilli were present. The vacuolated form was not met with. A pellicle formed on the surface three days later and the culture was still found to be pure. Generations from these original growths were carried on in bouillon and gelatine and agar, and these remained quite pure for some weeks, when great fouling occurred in many tubes.

This bacillus, as far as we could judge, exactly resembled the one obtained in our earliest experiments. It stained excellently with Ziehl's solution and resisted decolorisation with 26 per cent. nitric acid. As is figured in Fig. 2, Plate III, a hull becomes very apparent around the bacilli, and this is capable of being well shown with watery methyl-violet and to a less extent by the method employed for showing the capsule of Friedländer's *Pneumococcus*.⁵⁹ The aggregation of these bacilli into groups is most peculiar, and the appearance figured in Plate III, Fig. 4, recalls very much the arrangement within the tissues, masses of bacilli being collected together into clusters, due possibly to the nature of the hull of the bacillus.

Cultivation Experiments with Juice from Leprous Tubercle.

On July 8th an unbroken tubercle on the elbow of the same leper was scraped with a knife, washed with carbolic soap and perchloride solution, and after puncture with every precaution, leper juice was collected in a sterile capillary tube and dropped into glycerine-bouillon. Six tubes were prepared in this way, of which four rapidly became fouled with growth of *Bacillus Subtilis* and staphylococci; the other two remained pure and were kept in the incubator at 37°C. In both these tubes free bacilli, undistinguishable from Leprosy Bacilli, were found about the tenth day. We did not have the opportunity of continuing this culture on agar.

As will be seen from the next section, all attempts to establish the pathogenic character of the three bacilli described above were without success, and consequently it is impossible to affirm with certainty that the cultivation of the *Bacillus Lepræ* has been accomplished by us. We do, however, claim to have obtained the same

(⁵⁹) Friedländer, op. cit.

bacillus from the tissues of lepers by three different methods. Allowing that the form of this cultivated bacillus is slightly broader than that met with in the tissues, this alone would not constitute a serious distinction, for, as is well known, bacilli, which are specific pathogenic parasites, vary greatly in size, according to the nature of the medium⁶¹ on which they grow, and further the same specific bacillus varies in size according to the animal in which it occurs.⁶² Lastly, the aspect of the cultivated *Bacillus Lepræ* is unknown to us. Also, as far as staining reaction and measurements can serve as criteria, the bacillus we have figured does correspond with that of the tissues. In the course of numerous foulings of cultures neither this form nor that of the vacuolated bacillus were ever found as a contamination, and we are convinced that both these forms were obtained from tubercular masses. No skin was adherent to the pieces used as a source of culture. It is on the staining properties that we rely, and we believe that we have cultivated two bacilli of different morphological form which respond to the staining methods used as diagnostic of the *Bacillus Lepræ*. However, the rapidity of the growth of the subcultures greatly exceeds that of the original. This has surprised us, for we should have expected that the rate of multiplication of the specific bacillus of a disease such as leprosy, which is so essentially chronic, would have been slower.

Quite recently Campana⁶³ found in cultivations of tissue from tuberculous leprosy a bacillus which morphologically entirely resembled *Bacillus Lepræ*. Treated by Ehrlich's method this did not take on a double staining. In two cases this bacillus grew in agar-agar and in meat peptone to which 3 per cent. of grape sugar was added. The bacillus did not grow in fluid media. Inoculation experiments on rats were negative. Campana does not infer that this bacillus is identical with *Bacillus Lepræ*, since he only found a resemblance between the two. It is perhaps possible, though we do not incline to this view, that the bacillus described by Campana may resemble that of our cultures.

We refrain from definitely asserting that our culture is the Leprosy Bacillus, since it apparently possesses no pathogenic power. Possibly leprosy, like syphilis and cancer,⁶⁴ is an essentially human

(⁶¹) See Buchner's figures of *Bac. Anthracis* in Zopf's *Die Spaltpilze*.

(⁶²) K. Huber, *Deutsche Med. Wochens.* 1881, No. 3. *Bac. Anthracis* is largest in mice, smallest in the cow, and of a mean between these in rabbits and guinea-pigs.

(⁶³) Campana (*Reforma Med.* No. 14, 1891), quoted from *British Medical Journal* of June 20th, 1891.

(⁶⁴) Hanau's rats became affected with cancer, not in consequence of the introduction of cancer from the human subject, but of a cancerous growth taken from another rat.

disease. We propose to continue these cultivation experiments as opportunity offers.

VI.—TRANSMISSIBILITY OF THE DISEASE BY EXPERIMENT.

Keanu, a Hawaiian man in Oahu Gaol, in consideration of the commutation of his sentence of capital punishment, voluntarily submitted to inoculation of a leprous tubercle under the skin of the left fore-arm. This was performed by Dr. Arning on September 30th, 1884,⁶⁵ and at this time no symptom of leprosy was present, and no family history of the disease could be obtained. In four weeks' time the patient suffered from rheumatic pains in the left shoulder, and subsequently also in the elbow and wrist joints. Accompanying these symptoms there was a painful swelling of the ulnar and median nerves; fever was absent. By the end of six months the neuritis had gradually decreased, and a small leprous tubercle had formed on the keloid growth at the site of inoculation. Leprosy Bacilli could be detected in the tissues of this scar sixteen months after inoculation. Definite symptoms of leprosy existed in September 1887, and in another year the patient was at the full height of the disease.

In estimating the value of this experiment it must be remembered that Keanu's son, nephew, and maternal first cousin were lepers either before or after the experiment.⁶⁶ But apart from this, which we are not inclined to use as a strong argument, Arning's experiment, in order to be scientifically free from objection, needs to be performed with reference to the question of race and habitat. Hawaiians become lepers with great frequency, and the disease may be regarded as endemic at the present time in the Sandwich Islands. The possession of a criterion of the *living* Bacillus Lepre is also of the first importance in experiments of this nature.

Attempts to transmit the disease to man were made more than thirty years ago by a Norwegian physician, who endeavoured to inoculate himself and other individuals with leprosy by the introduction under the skin, of leprous tubercles, blood, and pus from lepers. These efforts to transmit the disease uniformly failed.

Profeta⁶⁷ has similarly failed to inoculate himself or others with leprosy, and Cagnina⁶⁸ met with the same result. Numberless phy-

(⁶⁵) Journal of the Leprosy Investigation Committee, No. 2, 1891, page 132, where Arning's paper in Archiv. für Dermat. und Syph. January 1891, is translated.

(⁶⁶) Report on Leprosy in Molakai, by Dr. Swift, who attended Keanu's relations.

(⁶⁷) Profeta "Sur l'Elephantiasis des Grecs"—Giornale intern. dell. sc. med., 1884, quoted by Leloir.

(⁶⁸) Quoted by Leloir, p. 238.

sicians and surgeons during the performance of autopsies, or operations on lepers, have accidentally wounded themselves, and there is no case recorded of the subsequent appearance of leprosy.

Experimental inoculations upon animals have never succeeded in establishing leprosy as it is clinically seen in man. A visceral leprosy, if such a term may be employed, has however been obtained by some experimenters, though a far greater number of observers have failed.

In Neisser's observations,⁶⁹ a freshly extirpated leprous tubercle was introduced into the peritoneal cavity, subcutaneous tissue, and anterior chamber of the eye of rabbits and dogs. The value of these experiments, in some of which there was perhaps a local lepra, as well as some subsequent negative observations in which "cultures" and leprous tubercles were used, is thus summarized after a criticism of the work of others in this direction. "Leprosy in animals has not yet been established by certain convincing experiments."⁷⁰

Köbner⁷¹ and Hansen⁷² (both of whom inoculated monkeys) obtained negative results. Damsch,⁷³ after implantation of leprous tubercle in the anterior chamber of the eye of rabbits, described an infiltration of the iris, ciliary body, and Descemet's membrane, with cells containing Leprosy Bacilli. In consequence of the enormous number of bacilli, he believed that a definite multiplication of these had occurred within the body. But it is the case that pieces of tubercle left in ordinary water for some weeks similarly shows the water to be full of Leprosy Bacilli, which no doubt are washed out of the mass, and it is quite conceivable that the results obtained by Damsch may be a simple mechanical process, especially since a distribution of the bacillus within the body did not occur. The implantation experiments beneath the skin and into the peritoneal cavity of cats do not appear to have led to more than the results obtained by Neisser, that is, a possible local lepra. Campana's⁷⁴ experiments consisted in numerous inoculations of leprous tubercle on the vascular comb and beard of fowls. A local tumour frequently formed at the seat of inoculation, and large cells produced in the inflammatory process took up the Leprosy Bacilli in the same manner as inorganic particulate foreign bodies would be ingested by white blood corpuscles. Campana

(⁶⁹) Virch. Archiv. Vol. 4, 1881, p. 534.

(⁷⁰) Virch. Archiv. 1886, Vol. 103, p. 384.

(⁷¹) Virch. Archiv. 1882, Vol. 83, p. 282.

(⁷²) Congress de Copenhague, 1884, quoted from Leloir.

(⁷³) Virch. Archiv. 1883, Vol. 90, p. 20.

(⁷⁴) Campana, Archiv. suela. Scienza Med. 1883, and Clinica Dermatologica, 1883, quoted from Neisser.

believes that the results obtained by Damsch are capable of the same interpretation. Vossius,⁶⁵ by inoculation in the anterior chamber of the eyes of rabbits, found an extensive accumulation of Leprosy Bacilli in the cornea, iris and ciliary body, but a distribution of these bacilli throughout the body, and the establishment of visceral or cutaneous lesions, is necessary before these can be considered other than implantation experiments.

Hillairet and Gaucher⁶⁶ inoculated a pig with leprous tubercle; E. Vidal repeated the experiment, and the implanted mass a year later showed numbers of Leprosy Bacilli, though none were to be found in the surrounding tissue; these observations may therefore be regarded as negative. Thin, Kaurin,⁶⁷ Arning, Rake,⁶⁸ Bordoni-Uffreduzzi (who failed to inoculate with his cultivated *Bacillus Lepræ*) have hitherto met with failure to establish leprosy in animals.

Hitherto the transmissibility of the disease to animals has succeeded only in the experiments of Melchor and Ortmann.⁶⁹ In rabbits they describe an intestinal and a lymphatic gland lepra as developed four months after the introduction of freshly extirpated leprous tubercle into the anterior chamber of the rabbit's eye. After inoculation a subacute general infective disease is established, and the autopsy showed almost all the viscera (cæcum, lymphatic glands, spleen, lungs) to be infiltrated with nodules varying in size from a pin's head to a pea. In these nodules were quantities of typical Leprosy Bacilli. Numbers of observers,⁷⁰ who have seen the specimens obtained from these disseminated nodules, are satisfied that a genuine visceral leprosy was established by the experiments of these observers, and the conclusion that under certain circumstances leprosy is an infective disease transmitted by the agency of the *Bacillus Lepræ*, may fairly be made from these experiments. At the same time it must be stated that, although a few animals became acutely infected, a far greater number escaped infection.

With the exception of the last-mentioned experiments, it may be considered that the proof of the inoculability of leprosy has not yet

(⁶⁵) Bericht der XVI Vers. der Opthal. Gesell. Heidelberg, 1884, quoted from Neisser.

(⁶⁶) Société de Biologie, 1881, quoted from Les Bacteries, p. 760, by Cornil and Babès.

(⁶⁷) "In spite of several experiments I have not been able to prove Dr. Ortmann's inoculation of the *Bacillus Lepræ* on rabbits." Journal of the Leprosy Investigation Committee, No. 2, 1891, p. 68.

(⁶⁸) Reports of Trinidad Leper Asylum, 1884, 1885, 1886, 1887, 1888, 1889.

(⁶⁹) Berl. Klin. Wochen. 1885, No. 13, and Ibidem, 1885, No. 9.

(⁷⁰) Among others Arning (p. 117, Journal of the Leprosy Investigation Committee No. 2) who writes "there is no doubt to my mind that Dr. Ortmann of Königsberg has succeeded in inoculating animals with leprosy. I have seen his specimens and am fully convinced of the accuracy of his results."

Campana, Wesener (Munch. Med. Wochen. 1887, No. 18) and others have adversely criticised the above experiments.

been given. Had Melchor and Ortmann worked with a pure culture of *Bacillus Lepræ* and again recultivated the bacillus found in the organs, the proof would have been complete, and Koch's postulates for the specific pathogenic nature of a bacillus would have been satisfied. As mentioned above, Bordoni-Uffreduzzi failed to inoculate with his cultivated *Bacillus Lepræ*.

Our experiments were commenced at Almora on April 3rd, 1891. Pieces of freshly extirpated tubercle from the wrist were removed with all antiseptic precautions, and a piece of the jejunum of a dog about 4 inches in length, was resected, washed out with sterilized warm water, then closed at one end, the piece of tubercle introduced, and the other end closed. The mesentery was left attached. The gut was now joined by double rows of Lembert's suture and the abdomen closed. Two dogs were operated on in this way; the first died on the sixth day. Considerable peritonitis was found. The sutures were in place, and there was no obstruction of the bowel at this point. The resected loop contained a yellowish fæcal liquid. In this liquid the piece of tubercle lay unchanged. All the viscera appeared healthy. The fluid in the resected bowel and the mucous membrane were examined microscopically. Plenty of Leprosy Bacilli were found in half the specimens of the former; the latter were negative. The second dog died on the sixth day. Resected ends of the bowel had almost separated. In the resected loop, which was gangrenous, the piece of tubercle lay unchanged. Cover-glass specimens of the tubercle, the contents of the loop, and the submucous layer of the bowel wall were taken. In the first, were quantities of *Bacillus Lepræ*, in the second, three specimens contained *Bacillus Lepræ*, and one showed none, in the third, no bacilli were found. These two experiments were performed chiefly with a view to estimate the possibility of success in the operation. The piece of tubercle would have remained in the loop, and had distribution of the bacilli occurred, these would in all probability have been found either in the lymphatic glands or in the fluid of the thoracic duct. The admixture with digested food and mixed intestinal secretions, such as the bile, which might affect the activity of *Bacillus Lepræ*, would also have been obviated. The bacilli found in the contents of the resected loop were probably only mechanically washed out of the introduced tubercle.

Further experiments were carried on in the laboratory built by the Indian Government for the Commission at Simla. Cultures obtained from blister fluid and leprous tubercle were mixed with about twenty times their volume of .65 per cent. saline solution, and the mixture so obtained was used for all the inoculations at Simla.

On June 5th, 1891, a minute quantity, about one-fourth of a minim, of a culture of the first generation on agar of the bacillus which was vacuolated (see Cultivation Experiments) was introduced with antiseptic precautions into a pocket in the left ear of a pariah dog, and at the same time about 1 minim of the original culture of the bacillus (which morphologically appears like *Bacillus Lepræ*) in bouillon, into a pocket of the right ear. Both these cultures at the time of inoculation were examined and found to be pure. On June 9th a small subcutaneous lump was felt on the left ear, but none on the right. On June 15th both ears at the points of inoculation presented distinct local thickening, and about 1 minim of the second generation of the vacuolated bacillus on agar was mixed with twenty times its volume of .65 saline solution, and 1 minim of this subcutaneously injected into the right ear about one inch from the thickened nodule. One minim of the culture (fourth generation on agar) was introduced into the left ear. On July 2nd this dog was injected at the same place in both ears with 1 minim of the original culture from tubercle in bouillon. This was fourteen days old, and the solution injected was 1:20 saline. This dog died on July 15th, with symptoms of salivation, wasting, and multiple subcutaneous abscesses on limbs and abdomen. On the left ear, but only at the site of the last inoculation, there was distinct thickening of the cartilage shown by section; on the left ear nothing was evident. The viscera were healthy, but the axillary glands were somewhat enlarged. The lungs, liver, spleen, mucous coat of stomach, testis, kidney, pus from the abscesses, and tissue from the local thickening of the ear were examined microscopically by means of cover-glass preparations. In no instance were any specimens of the bacilli described by us present.

On June 3rd another dog was chloroformed, the peritoneum was opened, and about one minim of the culture on gelatine from the culture on agar of the bacillus resembling *Bacillus Lepræ* was introduced. The culture was examined and was found to contain plenty of these morphologically similar bacilli.

The dog was killed and examined on August 14th. There were adhesions of the peritoneum in the neighbourhood of the cecum. There were no enlarged glands or growths. The liver, spleen, kidneys, stomach, intestines, heart, lungs, parotid and submaxillary glands were all normal, and microscopic examination showed no bacilli.

On July 8th, and subsequently at intervals of about a week, another dog was injected in the right axilla with about five minims

of a solution of a culture on gelatine from the culture in bouillon of the bacillus obtained from a leprous tubercle by the second method described above, *viz.*, by introducing a piece of leprous tubercle, removed with all possible precautions, into bouillon. This dog was killed and examined on August 15th. All the viscera were normal, but the mediastinal and mesenteric glands were enormously enlarged. Microscopic examination showed no bacilli in the viscera or glands.

On June 11th, and subsequently at intervals, a rabbit was inoculated beneath the skin of the abdomen with a solution of the fourth generation on agar from the culture obtained by the first method, *viz.*, cultivation in blister fluid. The rabbit was killed and examined on August 11th. The liver contained two white growths which showed psorospermia under the microscope. The other viscera were healthy, and examined microscopically no Leprosy Bacilli were found.

On June 11th, and subsequently at intervals, another rabbit was injected on the right side of the abdomen with the same solution as the last. It was believed that the liquid entered the peritoneal cavity. The rabbit was killed and examined on August 12th. Nothing was found at the point of inoculation. The suprarenal capsules were slightly enlarged. All the other viscera were healthy. No Leprosy Bacilli could be found in the suprarenal capsules or in the other viscera.

On July 2nd the anterior chamber of the left eye of another rabbit was injected with two minims of a solution of culture obtained by the second method. On July 8th the anterior chamber of the right eye of the same rabbit was inoculated in the same way. The iris was wounded during the inoculation. Both eyes healed perfectly and no growth was visible in the anterior chambers. The rabbit was killed and examined on August 13th. The liver showed a semi-purulent cyst, which was found to contain psorospermia. The other viscera were normal, and there were no enlarged glands. Four specimens of the aqueous humour of the right eye were examined microscopically. One bacillus comparable with the culture was found. This was probably a portion of the original injection. No growth of bacilli was found. The lens and cicatrix on the same side were examined with negative result.

On June 13th, and subsequently at intervals, another rabbit was inoculated in both ears and in the left axilla with one minim of a solution of the fourth generation on agar of the culture obtained by the first method. On June 24th a slight thickening was noticed at the site of inoculation, and a drop of blood and fluid taken from this place was stained and examined. It showed four or five deeply stain-

ed pink bacilli, and in one part of the field a group of faintly stained bacilli, matted together, and strongly suggestive of the culture introduced. The rabbit was killed and examined on August 10th. There was some thickening at the points of inoculation on the ears, but no bacilli were to be found in them. The liver contained two semipurulent cysts showing psorospermia. The other viscera were healthy. There were no enlarged glands. No Leprosy Bacilli were found in any part of the body.

On June 24th, a monkey (*Macacus rhesus*) was injected on the inner side of the right thigh with about four minims of solution of the fourth generation on agar of a culture obtained by the first method. On July 1st it was injected in the left groin with about two minims of a solution of the original culture from a leprosy tubercle obtained by the second method. The monkey never showed any local thickening or evidence of infection, and when last seen, on August 24th, was, to all appearance, healthy.

From the above series of experiments it will be seen that in the two dogs operated on at Almora, Leprosy Bacilli were found in the resected portions of bowel, but that these were in all probability mechanically washed out of the introduced pieces of tubercle. In the Simla experiments a few bacilli were found in one ear of a rabbit at the point of inoculation, and a single bacillus was found in the anterior chamber of another rabbit, also close to the site of inoculation. In view, however, of the very small number of these bacilli, and of the absence of any general diffusion through the bodies of the rabbits, we can only regard the bacilli as portions of the cultures actually introduced. Indeed, these cultures did not appear to be pathogenic. There was nothing to point to a multiplication even at the point of inoculation. We therefore consider all our inoculation experiments absolutely without result.

Interesting negative evidence was also obtained at Ahmedabad, where we examined twenty-one fowls which had lived for periods of four or five years in the compound of the Leper Asylum, and had been in the habit of pecking the ulcerated feet of the lepers to such an extent as to necessitate their removal. They had been kept apart for our inspection. All these fowls, when we examined them on August 29th, were healthy and in good condition. Surgeon Quicke informed us that a fowl had recently died in the Leper Asylum compound which had a large tumour under one wing. Unfortunately the specimen was not kept as he had ordered, and the opportunity of examining it was lost. From Dr. Quicke's description, however, the tumour appeared to be too large for a leprosy

node. From the numerous recorded experiments of observers in various parts of the world, and from our own attempts at inoculation, we consider it extremely doubtful whether a true leprosy, such as we recognise clinically, can be produced in animals. In the absence of this step, Koch's postulates remain unfulfilled, and it is impossible to say whether the cultures we obtained from leprosy tissues and fluids are growths of Leprosy Bacilli or not. Further experiments which we are determined to prosecute with reference to cultivation and transmissibility to animals, will, we hope, tend to elucidate the ætiology of a disease which we believe to be due to a specific bacillus.

APPENDIX II.

Laboratory Work at Simla,

BY

A. A. KANTHACK.

Most of the work described in this short appendix was done conjointly with the late Surgeon-Major A. Barclay. As, however, his untimely and deplorable death occurred before these lines were even begun, the sole responsibility of all statements contained therein must rest with me. The results of this portion of the practical work will be stated as briefly as possible, as they convey nothing new, and are mostly negative, or old established facts.

Appendix II.

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I.—EXAMINATION OF TISSUES AND DISCHARGES.

The method of staining for Leprosy Bacilli in each instance was that generally known by the name of Koch-Ehrlich, or Ziehl's modification thereof:

(a) Tubercles from the ear of a tubercular leper, an inmate of the Tarn Taran Asylum.

Typical masses of bacilli were found in the corium of the skin, the epithelium in all specimens being free. The bacilli were arranged in irregular clusters, but at times in small chains of two or three rods. Most of them are pointed, a few however having blunted ends. The other physical characters are so well known as not to deserve special mention. It may, however, be noticed that in some specimens isolated fuchsin bodies, similar to those found in Rhinoscleroma and the fungoid disease (Mycetoma) were found.

(b) Discharge from sores of anæsthetic lepers inmates of the Subathu Asylum.

Five patients of a purely anæsthetic type were chosen and ten cover-glasses prepared from each. Of fifty cover-glasses ten only showed positive results, and these were all taken from one patient. Here Leprosy Bacilli, in masses or scattered about separately, could be found in almost every field.

(c) Discharge from sores of mixed lepers belonging to the same Asylum.

Two patients were selected and again ten cover-glasses prepared from either. The result was positive in one instance.

(d) Nerve from a purely anæsthetic case.

Surgeon-Major E. Lawrie, while performing the operation of nerve-stretching, removed small pieces of the greatly enlarged ulnar nerve.

Cover-glass preparations gave no results. Sections of the nerve, hardened in alcohol and stained in the usual manner, revealed a few bacilli between the fibrillæ, and also numerous giant cells similar to those observed in a tuberculosis, but smaller. Some of the giant cells contained from one to three Leprosy Bacilli.

(e) Nerve from a purely anæsthetic case.

This specimen was also obtained through the kindness of Surgeon Major E. Lawrie. The result of the microscopic examination was negative, although the piece was excised from a highly diseased part of the nerve. Round cells resembling leucocytes were found in large numbers; giant cells were absent.

The nerve in each case, as exposed by Dr. Lawrie, was much thickened, transparent and greyish-yellow, and hard to the touch. The microscope revealed besides the above-mentioned cells an atrophy of most of the primitive fibrillæ and also a well marked fatty metamorphosis of the round cells, especially visible in unstained specimens.

(f) A discoloured anæsthetic patch.

Surgeon-Major Lewtas kindly removed a small piece of skin from an anæsthetic discoloured patch of a leper. No bacilli were found in any of the forty-three sections prepared.

(g) Itch pustules of—

(1) two anæsthetic cases and

(2) two mixed cases from the Madras Asylum.

The pustules were situated on apparently healthy portions of the skin. Six cover-glasses were prepared from each case, but the result was negative, no leprosy bacilli being found.

(h) Bulla on the dorsum of the hand of an anæsthetic case (Tanjore). Ten cover-glasses were prepared and stained, but all with negative result.

The patient was afflicted with pure anæsthetic leprosy, and had paræsthesia of both hands. The ulnar nerves were both thickened. The bulla was spontaneous in origin, and not due to any injury or burn. The patient spoke with confidence on this point, and considering that there was only a slight loss of sensation, there is no reason to doubt him, and the bulla must be regarded as a sequela of the nervous lesion.

II.—EXAMINATION OF BLOOD AND SERUM.

(a) Blood and lymph obtained by pricking a tubercle.

Two patients from the Subathu Asylum were employed, and after pricking the tubercle pressure was applied, so that with the blood the juice of the tissues was squeezed out.

Twelve cover-glasses were prepared, and all the specimens showed the characteristic bacilli, mostly in cells and masses. It was impossible to obtain pure blood from a vessel.

(b) Blood obtained by pricking an apparently healthy but anæsthetic part of a mixed case.

Two patients from the same Asylum were again chosen, and after pricking the skin pressure was applied to the part. Twenty cover-glasses were prepared, and in two Leprosy Bacilli enclosed in cells were obtained. As, however, these men presented extensive cutaneous lesions, it is difficult to say whether the bacilli had not been shed from other parts of the body, and thus reached the cover-glass as impurities, so to speak, especially when it is remembered that only two out of twenty specimens showed bacilli.

(c) Blood obtained by pricking the dorsum of the foot of purely anæsthetic cases.

Six patients, three from Subathu and three from Hyderabad, were employed, and though sixty specimens were prepared and examined in no case was a positive result obtained.

(d) Lymph or juice pressed out of tubercle after previous ligature. Every specimen (four in number) was swarming with Leprosy Bacilli.

(e) Blisters raised over tubercles.

Four patients were employed and forty specimens of the exuded fluid examined. The clear serum was free from bacilli in all instances. In one case the blister subsequently became sero-purulent, and of six specimens made of this fluid one contained typical bacilli enclosed in cells. The pustule was punctured, and the collapsed pellicle removed, and next day the soft crust examined. Of six specimens four showed numerous clusters of bacilli. It seems, therefore, an uncommon occurrence to find bacilli in absolutely clear serous blister fluid. This does not seem surprising, considering that the greater part of this fluid comes from the vessels, and excepting epidermal debris only contains leucocytes. Blistering is, however, different from vaccination, where the irritant is inoculated more deeply into the tissues, and it may be possible that in this manner cells in the corium containing Leprosy Bacilli are set free with the exuded fluid.

(f) Blisters raised over apparently healthy parts of skin of tubercular lepers.

The same patients were employed, and the same number of

specimens prepared, however with uniformly negative result.

- (g) Blisters raised over apparently healthy skin of anæsthetic lepers.

Three patients were blistered, and thirty cover-glasses stained, but bacilli were not found in a single instance.

III.—EXAMINATION OF SECRETIONS.

- (a) Saliva—

The saliva of three tubercular cases with extensive facial lesions was examined at the Subathu Asylum.

Thirty specimens were prepared, and Leprosy Bacilli, mostly in clusters and embedded in cells, were found in every specimen.

- (b) Nasal secretion—

Two patients suffering from extensive facial tubercular leprosy were selected. Except that minute tubercles were visible on the ala nasi, the nose was quite healthy. Yet all the twenty specimens stained and examined, contained Leprosy Bacilli in fair number.

- (c) Vaginal secretion of a tubercular leper—

Fifty specimens were examined, but no bacilli found.

- (d) Menstrual discharge of an anæsthetic leper.

Thirty specimens were examined, but no bacilli found.

The chief results will now be given in a tabular form:—

TABLE I.

Source of material.	Number of patients examined.	Number of specimens prepared.	RESULT.
(1) Nerve of anæsthetic leper	2	...	Positive in one case.
(2) Anæsthetic discoloured patch	1	43 sections	Negative in all specimens.
(3) Discharge from sore of anæsthetic leper	5	50	{ Positive in 10. Negative in 40.
(4) Discharge from sore of mixed leper	2	20	{ Positive in 1. Negative in 19.

Table I—continued.

Source of material.	Number of patients examined.	Number of specimens prepared.	RESULT.
(1) Itch pustules of anæsthetic leper	2	12	Negative in all cases.
(2) Itch pustule of mixed leper	2	12	Ditto.
(3) Bulla over dorsum of hand of an anæsthetic leper	1	10	Ditto.
(8) Blood and lymph from a tubercle	2	12	Positive in all cases.
(9) Blood and lymph from healthy but anæsthetic part of skin from a mixed leper	2	20	{ Positive in 2. Negative in 18.
(10) Blood obtained by pricking dorsum of foot of a purely anæsthetic leper	6	60	Negative in all cases.
(11) Juice obtained from tissues of a tubercle	1	4	Positive in all cases.
(12) Blister over a tubercle	4	40	Negative in all cases.
(13) Pustule over a tubercle	1	6	{ Positive in 1. Negative in 5.
(14) Crust from (13)	1	6	{ Positive in 4. Negative in 2.
(15) Blister over healthy skin of tubercular leper	4	40	Negative in all cases.
(16) Blister over healthy skin of anæsthetic case	3	30	Ditto.
(17) Saliva of tubercular leper	3	30	Positive in all cases.
(18) Nasal secretion of tubercular leper	2	20	{ Positive in 14. Negative in 6.
(19) Vaginal discharge of tubercular leper	1	50	Negative in all cases.
(20) Menstrual discharge of anæsthetic leper	1	30	Ditto.

IV.—EXAMINATION OF WATER FROM TANKS FREQUENTED BY LEPEERS.

- (a) Water from a tank at Bombay, much frequented by lepers.

Only ten specimens were prepared and these were all negative.

- (b) Water from a tank at Tarn Taran, much frequented by lepers. Hundred specimens were prepared: fifty were stained according to Ziehl's modification of Koch-Ehrlich's method and another fifty according to Baumgarten's method. In no specimen could any Leprosy Bacilli be found.

V.—DUST AND EARTH FROM LEPER HUTS OF THE TARN TARAN ASYLUM.

- (a) From hut inhabited by a tubercular leper with ulceration on the right foot.
 (b) From hut inhabited by a tubercular leper with ulcers on both feet.
 (c) From hut inhabited by a tubercular leper with ulcers on both feet.

In each case one hundred specimens were prepared: fifty were stained according to Koch-Ehrlich's method, fifty according to Baumgarten's method. In all three hundred specimens the result was negative.

- (d) From hut inhabited by an anæsthetic leper with ulcerations on all extremities.
 (e) From hut inhabited by an anæsthetic leper with ulcerations on both feet.
 (f) From hut inhabited by an anæsthetic leper with ulcerations on both feet.

In each case fifty specimens were prepared: twenty-five were stained according to Ziehl's method and twenty-five according to Baumgarten's method.

In all hundred and fifty specimens the result was negative.

These results will be given in tabular form:—

TABLE II.

Source of material.	Number of specimens examined.	Method.	Result.
(1) Water from tank at Bombay	10	Ziehl's	Negative.
(2) Water from tank at Tarn Taran	100	{ 50 by Ziehl's . 50 by Baumgarten's }	Ditto.

Table II—continued.

Source of material.	Number of specimens examined.	Method.	Result.
(3) Dust from hut of tubercular leper with ulcers on one foot.	100	{ 50 by Koch-Ehrlich's 50 by Baumgarten's }	Negative.
(4) Dust from hut of tubercular leper with ulcers on both feet	100	Ditto	Ditto.
(5) Dust from hut of tubercular leper with ulcers on both feet	100	Ditto	Ditto.
(6) Dust from hut of anæsthetic leper with ulcers on all extremities	50	{ 25 by Ziehl's 25 by Baumgarten's }	Ditto.
(7) Dust from hut of anæsthetic leper with ulcers on both feet	50	Ditto	Ditto.
(8) Dust from hut of anæsthetic leper with ulcers on both feet	50	Ditto	Ditto.

VI.—IMPLANTATION OF LEPER TISSUE INTO ANIMALS.

On January 22nd five animals—one monkey, two cats, and two rabbits—were operated on in Dr. D. D. Cunningham's laboratory at Calcutta. The tissue was removed from the ear of a tubercular leper, and minute pieces removed from the centre of the excised mass, used for implantation. These particles were inserted either into the anterior chamber of the eye, or dropped into the peritoneal cavity. The operation in each instance was performed with sterilized instruments and all antiseptic lotions carefully avoided, sterilized water alone being used. The eye operations were performed on the monkey (one eye), one cat (both eyes), one rabbit (one eye), and the abdominal implantation practised on the other cat and rabbit. Unfortunately both the rabbits died before they came into my possession. The animals were left at the Zoological Gardens of Calcutta, and after the rains had set in sent up to Simla, where they arrived by the beginning of August in rather emaciated condition, due, no doubt, to the fatiguing journey.

I propose now to state briefly the result of these implantations,

(a) Cat, operated on January 22nd, 1891—

A particle from a leprosy tubercle of the size of a hemp-seed was deposited into the peritoneal cavity.

August 11th, 1891.—Excepting the emaciated appearance of the animal nothing abnormal could be detected. On killing the cat and making an autopsy, the original nodule was easily found in the omentum. It appeared larger, but this was evidently due to a new formation of fibrous tissue around it, and a delicate thread of fibrous tissue was traced from the nodule to the parietal peritoneum.

No dissemination whatever had occurred, the peritoneum, intestines, and other viscera being quite free.

On microscopic examination bacilli were found in the nodule, not different in shape and arrangement from those in any tissue removed from a tubercular leper. *The result is therefore absolutely negative.*

(b) Cat, operated on January 22nd, 1891—

An lidectomy was performed on both eyes and a particle from a leprosy tubercle of the size of a hemp-seed inserted into either anterior chamber. No reaction whatever occurred, no iritis or conjunctivitis, and the corneal wound healed well.

August 11th, 1891.—The animal was somewhat emaciated; but otherwise perfectly healthy, and excepting in the eyes no changes could be detected anywhere. The media of both eyes were clear to naked eye examination and to inspection by focal illumination and the ophthalmoscope. No iritis could be observed in either eye. The nodule was plainly seen in the aqueous humour and was apparently undiminished in size.

(1) *Left eye.*—The nodule was visible on the temporal side, being fixed by a small thread of fibrous tissue to the scar in the cornea on the one hand, and to the adjoining part of the iris on the other, so that it could perform only very limited movement. The corneal scar was partly vascularised, but otherwise the cornea was perfectly clear. The iris was normal to all appearance and only slightly swollen at the insertion of the fibrous thread which connected it with the nodule. The aqueous humour was clear.

A dissection confirmed the observations of this examination.

Microscopic Examination.

Many cover-glass preparations were made of the aqueous humour, and all contained Leprosy Bacilli in fair number. Two or three masses, evidently shed from the nodule, were found in each specimen, but loose and independent bacilli could not be detected. It is thus highly improbable that the bacteria had grown or multiplied in the aqueous humour. The eye was carefully washed with sterilized water, and cover-glass preparations made of the iris. Near the site of the implanted nodule, where the thickening in the iris existed, many Leprosy Bacilli were found, but the same, though much more scantily, were observed in all parts of the iris examined. The bacilli occurred mostly in cells, but a number of loose ones were also seen amongst the tissue elements of the iris. Sections of the iris were not made through want of apparatus, but little pieces were squeezed between cover-glasses and then treated in the ordinary manner.

In view of the absence of all morbid appearances in the iris and the comparative scarcity of the bacilli in more remote parts of the iris, I am inclined to think that the organisms have either been deposited on, or taken up into, the substance of the iris from the aqueous humour into which they had been cast off from the original nodule through maceration. The original nodule presented no differences microscopically from tissue freshly removed from a tubercular leper, and was full of bacilli.

The retina and vitreous humour were quite free from leprosy, or other bacilli.

(2) *Right eye.*—The nodule was floating free in the aqueous humour. The cornea was clear and the linear incision made at the time of operation had healed, almost without leaving a scar. The iris and other parts of the eye-ball, both on ophthalmoscopic examination and oblique focal illumination, appeared unaffected. Microscopic examination was made of the original nodule and the aqueous humour only, the result being that the nodule was apparently unchanged, but the aqueous humour was quite free from bacilli. What remained of the two eyes has been reserved for examination by serial sections at a future time.*

* June 4, 1892: Such examination revealed an entire absence of bacilli within the tissues of the iris, choroid, etc.

- (3) A careful autopsy and search did not reveal any dissemination or secondary growths in any part of the body.

Therefore the result of these two animal experiments must be considered on the whole as highly unsatisfactory, as there is an absence of infection or, so far as can be judged by cover-glass preparations, of even a local proliferation. The want of inflammatory, or other general and defined changes in the iris, the clearness of the aqueous humour and of the cornea are all against a local contagion, to borrow a term from Virchow. The result of the experiment on the next animal was equally unsatisfactory.

- (c) Monkey, full grown, operated on January 22nd, 1891.—

An iridectomy was performed on the left eye and a piece of tissue from the same leper who supplied material for the other animals, was inserted into the anterior chamber. As it was impossible to prevent the animal from scratching, or interfering with its eye, some reaction, amounting to slight suppuration and hypopyon, took place, and the cornea also became slightly inflamed.

August 22nd, 1891.—The monkey was somewhat emaciated but otherwise no morbid changes were visible on the surface. After death a close examination of the eye revealed intense inflammation of the conjunctiva amounting to chemosis, inflammatory changes of the cornea, and suppuration in the anterior chamber. The wound in the cornea had not healed and matter from the anterior chamber was bulging out through the same. Subsequent dissection showed that the iris was almost completely destroyed, at least irrerecognisable in the mass of thick pus which had taken the place of the aqueous humour. The anterior surface of the lens was white and softened. The rest of the media were perfectly normal to the naked eye.

Microscopic Examination.

- (1) In the conjunctiva no bacilli were found by means of cover-glass specimens, except at the unhealed wound, whither most probably they had been discharged from the anterior chamber.
- (2) Matter from the anterior chamber contained bacilli, but only

in small quantity, two out of six cover-glass preparations showing the typical masses.

- (3) The other media of the eye showed no bacilli. All the other organs of the animal, excepting a few enlarged mesenteric glands, were apparently normal. The glands will be left for future examination, but it is highly improbable that they contain any bacilli, as the whole peritoneum appeared to be healthy. No reference has been made to the experiments of Damsch and others, because in the absence of sections it is quite impossible to speak with any confidence on such matters as local proliferation and dissemination. This portion of the work has been reserved for another time.*

VII.—CULTIVATION EXPERIMENTS WITH THE BACILLUS LEPRÆ.

The results of these experiments—premature and short-lived—have been published in the British Medical Journal (June 6th and 20th, 1891). As after a careful review of all the facts, benefiting by the kind criticism of Professors C. Fränkel and Baumgarten, I feel convinced that the artificially grown bacillus was not the Leprosy Bacillus; it will suffice simply to mention that attempts were made by me, in conjunction with the late Surgeon-Major A. Barclay, to cultivate the bacillus, but with no result. An explanation of this matter has already appeared in the above-mentioned journal.

ADDENDUM.

VIII.—EXAMINATION OF MOSQUITOES FOR LEPROSY BACILLI.

The following observations were made in conjunction with Surgeon-Major S. J. Thomson. The insects were obtained through the kindness of Surgeon-Major B. O'Brien, Civil Surgeon and Principal of the Medical College, Agra.

Three sets of mosquitoes were enclosed in muslin bags which were tied round the legs of three lepers. Of these one suffered from

* Cf. preceding footnote.

ulcerative tubercular leprosy, another from the tubercular form, and the third from anæsthetic leprosy. The bags were applied for a couple of hours in the morning, and again in the evening. At the end of four or five days many of the enclosed insects had died. These, with the few surviving ones, were put into separate bottles filled with absolute alcohol and sent up to the laboratory of the Commission at Simla for microscopic examination.

Ten mosquitoes were selected from each set. Some were gorged, especially those from the two tubercular cases, but most of the insects were of a natural size and undistended. They were placed in water to remove the alcohol, and then each set separately ground up in a small mortar with the least possible quantity of 75 per cent. salt solution, and ten cover-glass preparations made, using up the whole material. In this manner thirty specimens were obtained and stained for sixteen hours in anilin-fuchsin and treated in the usual manner. On microscopic examination no Leprosy Bacilli were found in any of the cover-glasses; a few cocci in some of the specimens were the only organisms seen.

Mosquitoes and Leprosy.

NATURE OF DISEASE.	Number of mosquitoes examined.	Number of specimens prepared.	RESULT.
(1) Tubercular leper without ulcers	10	10	Negative.
(2) " " with ulcers	10	10	Ditto.
(3) Anæsthetic leper	10	10	Ditto.

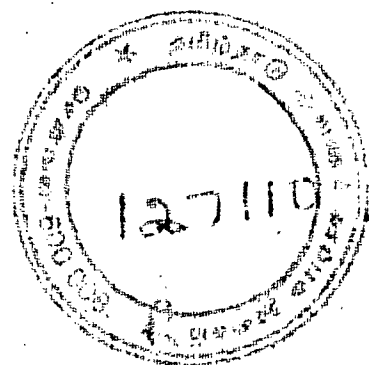
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