



ILEP TECHNICAL COMMISSION

Advisory Paper

Model Patient Card / Record (Leprosy)

2nd edition, London: ILEP, 2014

Introduction:

Completing a record card helps ensure accurate clinical records are kept; substantiates decisions and management plans; supports continuity of care; facilitates proactive and reactive risk management and provides useful information for quality improvement and research purposes.

It is essential to have accurate clinical documentation as leprosy is a chronic disease and many events can occur before, during and after treatment.

A patient card/ record should be maintained for persons who are diagnosed with leprosy. The card is necessary for efficient management of treatment. It should contain full information about the patient's identity, clinical details and treatment. The same card may also be used for surveillance.

As part of the process of creating the Model Patient Card, leprosy patient cards from 16 countries were reviewed, and their content and best practice were noted. A *Model Patient Card/ Record* was developed taking the following references into consideration:

List of References:

- 16 countries patient cards
- *Enhanced Global Strategy for Further Reducing the Disease Burden Due to Leprosy (2011-2015), Operational Guidelines*. New Delhi: World Health Organization, Regional Office for South-East Asia, 2009.
- *How to Recognise and Manage Leprosy Reactions (Learning Guide Two)*. London: ILEP, 2002.
- *A Guide to Leprosy Control*. 2nd ed., Geneva: World Health Organization, 1988.
- *Case Taking in Leprosy*. Karigiri: Karigiri Leprosy Education Programme (KLEP), Schieffelin Institute of Health Research and Training centre, 1985.

This Model Patient Card/Record can be taken as reference while developing / modifying leprosy patient cards / records at national, sub-national, and institutional levels.

Acknowledgments:

The diagrammatic codes are shared here with the kind permission of the Schieffelin Institute of Health Research and Training Centre, Karigiri, India.

Checklist for Patient Card/Record

Checklist Points	
1	Registration data
	1.1 Country
	1.2 Name and address of health facility
	1.3 Patient registration number
2	Personal data
	2.1 Name of the patient
	2.2 Sex
	2.3 Year of birth (or age)
	2.4 Place of birth
	2.5 Father's name / husband's name
	2.6 Present address
	2.7 Permanent address
	2.8 Nationality
	2.9 Number of years of residence at present address
	2.10 Telephone number
	2.11 Occupation
	2.12 Marital status
	2.13 Mode of detection
	2.14 Previous treatment details
	2.15 Patient status
	2.16 Contact history
2.17 Details of household contacts	
3	Disease status (initial) - leprosy
	3.1 Presenting symptoms
	3.2 Duration of presenting symptoms (in months & years)
	3.3 Numbers of skin patches
	3.4 Nerve status
	3.5 WHO disability grading (At the time of diagnosis)
	3.6 EHF Score (At the time of diagnosis)
	3.7 Type of leprosy
	3.8 Body charting
4	Details of other diseases
	4.1 Medical history
	4.2 General physical examination
5	Treatment details (MDT)
	5.1 Treatment monthly attendance
	5.2 Date of completing MDT or other treatment outcome (default, died, transferred out, change of classification)
	Body charting (at completion of the treatment)
6	Bacteriological examination (Slit skin smear)
	6.1 Skin smear results
7	Assessment of disability & nerve function
	7.1 Voluntary muscle test
	7.2 Sensory testing
8	Notes
	8.1 Record of reactions; complications; relapse etc.

Leprosy Patient Card / Record

LEPROSY PATIENT RECORD

National Leprosy Control Programme

1. Registration Data

Country	
State or province	
Name and address of health facility	
Patient registration number	
Date of registration	

2. Personal Data

Name of the patient	
Sex	Male / Female
Year of birth (or age)	
Place of birth	
Father's name/ husband's name	
Present address	
Permanent address	
Nationality	
Number of years of residence at present address	
Telephone number	
Occupation	
Marital status	Single/married/widow/widower/divorcee
Name, phone number and address of contact person in case of emergency	

Mode of detection	Contact survey/other surveys/voluntary/referred/ others (specify)
Previous treatment details	(Specify drug regimen, duration and year of previous treatment)
Patient Status	New/relapse after PB MDT/relapse after MB MDT/transferred in/readmission after DDS monotherapy/treatment after default
Contact History	(Any known leprosy patient within the family) – Yes / No

Details of household contacts				
Serial number	Name	Sex	Year of birth (or age)	Relationship to the patient
1				
2				
3				
4				
5				
6				

3. Disease Status (Initial) – Leprosy

Presenting symptoms	Patch/es, visible impairment, reactions, other (specify)
Duration of presenting symptoms (in months & years)	

Numbers of skin patches	One	2-5	> 5
Reactions - please encircle (Yes/ No); If yes , please encircle (Type 1 / Type 2)			

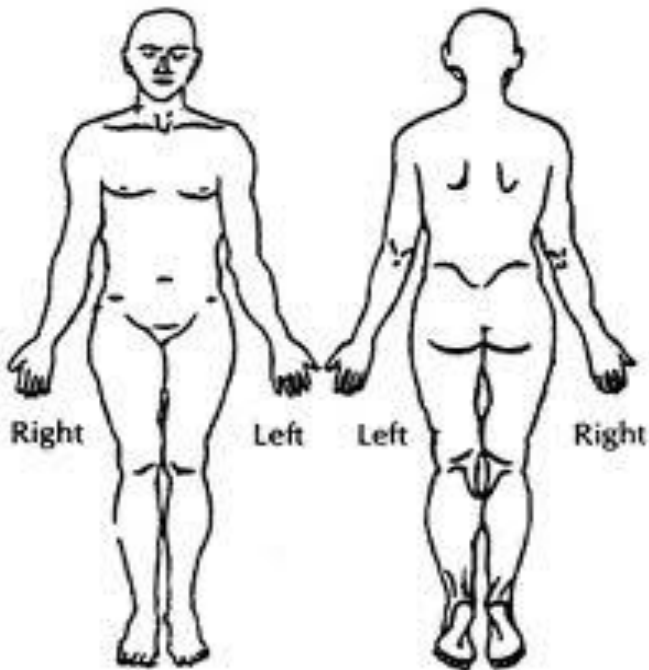
Nerve status		Ulnar		Median		Radial		LPN		PT	
		R	L	R	L	R	L	R	L	R	L
	Thickening/ Pain/ Tenderness										

WHO disability grading (At the time of diagnosis)		Eye	Hand	Foot	Key: Refer guidelines
	Right				
	Left				

EHF Score (At the time of diagnosis)	
--------------------------------------	--

Type of leprosy	PB	MB
-----------------	----	----

Body charting



Date of charting:

4. Details of Other Conditions:

Medical History: (Mention Yes / No)

Diabetes	Hepatitis	Tuberculosis	HIV/AIDS	Any other disease
----------	-----------	--------------	----------	-------------------

Other conditions:

Pregnancy	Drug allergy
-----------	--------------

General Physical Examination

Body weight:

5. Treatment Details

Drug regimen prescribed (tick the appropriate column)	PB MDT	MB MDT	Any other regimen (specify)
--	--------	--------	-----------------------------

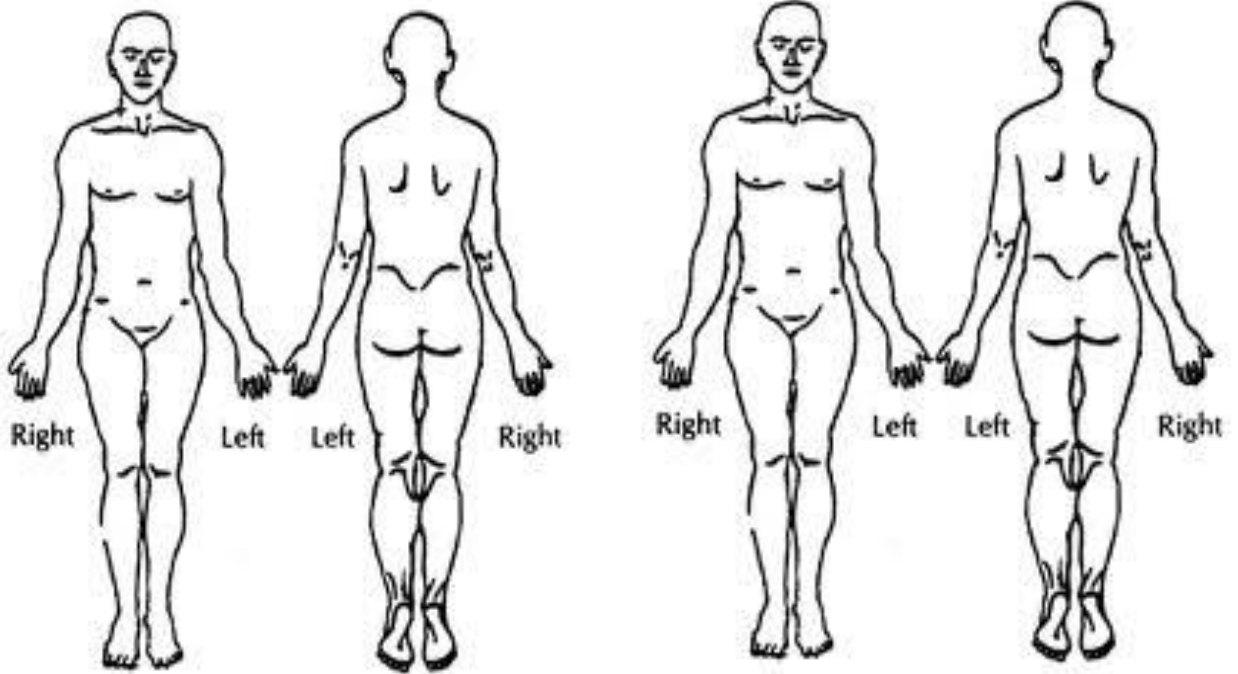
Treatment Monthly Attendance (Schedule of Monthly Supervised Doses)

Dose	1	2	3	4	5	6
Date						
Dose	7	8	9	10	11	12
Date						

(Any country that has chosen 24 months regimen for MB, can add similar boxes)

Date of completion of MDT or other treatment outcomes (default, died, transferred out, change of classification)	
--	--

(At completion of the treatment)



Date of charting:

Date of charting:

6. Bacteriological Examination (Slit skin smear)

Date				
Number of sites taken				
Highest BI at any one site				
Average BI				

7. Assessment of Disability & Nerve Function

Voluntary Muscle Test

RIGHT						LEFT					
← Date →											
Vision (0,1,2)											
Light closure lid gap in mm.											
Blink present / absent											
Little finger out											
Thumb up											
Wrist extension											
Foot up											
Disability grade hands											
Disability grade feet											
Disability grade eyes											
On date											
Max. (WHO) Disability Grade											
EHF score											
Signature of assessor											

Muscle power:

S = Strong

W = Weak

P = Paralysis

W = Weak





















Score of vision: counting fingers at 6 meters

0 = Normal

1 = Blurring vision

2 = Unable to count fingers

Sensory Testing

Date / Assessor	Palm		Sole		Comments
	RIGHT	LEFT	RIGHT	LEFT	
					
					
					
					
					

Key : (Put these marks/icons on the site where lesion is seen)

- ✓ Sensation Present within 3 cm
- S Contracture
- Scar/Callus
- ✗ Anaesthesia
- ⊗ Wound
- ⊕ Shortening Level
- ▬ Crack

8. Notes

Record reactions (indicate Type 1 or Type2); complications; relapse, etc.

Date	Notes (signs & symptoms; diagnosis; treatment details)

Guidelines

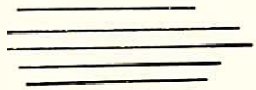
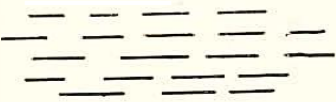

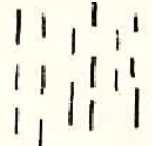
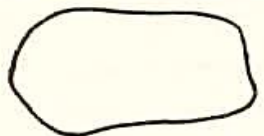
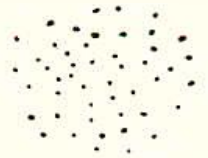

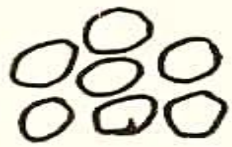
Guidelines on Completing the Patient Card







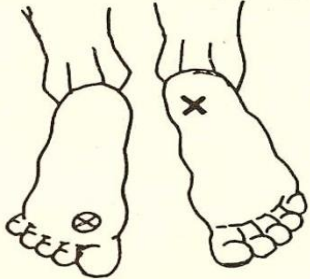
Name	Full name
Address	Full postal address and identifying marks near the house to facilitate tracing of defaulter
Age	Full years only
Duration of Disease	To be ascertained from case history to be written in months
Household contact	A household contact in leprosy means - any person of same dwelling with an untreated leprosy /index case for at least 6 months.
PB & MB	<p>A simple clinical rule is now used to divide patients into these two groups. The number of individual skin lesions is counted (this means that the whole body must be examined to make an accurate count).</p> <p>PB cases have up to five skin lesions in total. MB cases have six or more skin lesions.</p> <p>If a skin smear is done and is positive, the patient must be classified as MB irrespective of the number of skin lesions. If the smear is negative, the classification is decided by the number of skin lesions.</p>
General physical examination	This is necessary in all patients with confirmed diagnosis of leprosy. It is a prerequisite for the commencement of multidrug therapy. The objective is to determine contraindications or ailments that may preclude the use of drugs recommended in the MDT.
Date of first dose	Write date of giving first blister pack of MDT; client swallows medicine in the presence of health worker/ pharmacist.
Date of subsequent doses	Write date of collection of the next dose. In the case of a person who has taken accompanied MDT write the date in the first cell and connect that cell with the other cells (number of cells correspond to the number of extra blister packs taken) by a line with an arrow mark at the end.
Date of discharge	Write date of completion of last blister pack as day/ month/ year of discharge. Tick the status: if person has not completed the treatment, record defaulter, died, migrated or unknown as appropriate.
Defaulter	<p>Although every effort must be made to ensure that PB patients complete their treatment regimen in six months and MB patients in 12 months, the treatment regimen for PB leprosy must be completed within a maximum period of nine months. Similarly, the treatment regimen for MB leprosy must be completed within a maximum period of 18 months.</p> <p>A defaulter is an individual who fails to complete treatment within the maximum allowed time - frame. Thus, whenever a PB patient has missed more than three months of treatment or an MB patient more than six months of treatment, it is not possible for them to complete the regimen in the maximum time allowed and they should be declared as defaulters from treatment. If found, defaulters must be restarted on another full course of MDT.</p>



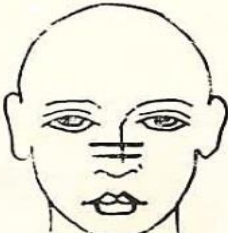

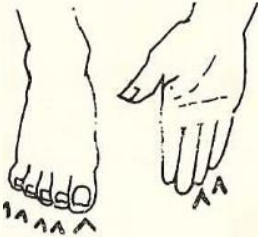
<p>Disability grading in leprosy</p>	<p>Every new case of leprosy must be assigned a “Disability Grade”, which records the condition of the patient at diagnosis. The grade is on a scale of 0, 1 or 2. Each eye, each hand and each foot is given its own grade, so the patient actually has six grades, but the highest grade given is used as the Disability Grade for that patient.</p> <p>WHO grading for the eyes:</p> <table border="1" data-bbox="395 405 1326 734"> <thead> <tr> <th>Grade</th> <th>Criteria</th> </tr> </thead> <tbody> <tr> <td>0</td> <td>No severe visual impairment (can count fingers at 6 meters; visual acuity > 6:60). No visible impairments. Normal blink reflex.</td> </tr> <tr> <td>1</td> <td>Loss of blink reflex and/or inability to hold the eyelids closed against moderate force to open them. No severe visual impairment (can count fingers at 6 meters - visual acuity > 6:60).</td> </tr> <tr> <td>2</td> <td>Visible impairments to the eye, severe visual impairment (cannot count fingers at 6 meters - visual acuity < 6:60) and/or any other visible damage to the eye (regardless of cause).</td> </tr> </tbody> </table> <p>WHO disability grading for the hands:</p> <table border="1" data-bbox="395 837 1311 1104"> <thead> <tr> <th>Grade</th> <th>Criteria</th> </tr> </thead> <tbody> <tr> <td>0</td> <td>Touch is felt on the palm of the hand; no muscle weakness or visible impairment.</td> </tr> <tr> <td>1</td> <td>At least 2 points on the hand where touch is not felt And/or muscle weakness is present on testing, but there is no visible impairment.</td> </tr> <tr> <td>2</td> <td>Visible impairment of the hand if it has occurred since the onset of loss of sensation and/or loss of muscle function due to leprosy.</td> </tr> </tbody> </table> <p>WHO disability grading for the feet:</p> <table border="1" data-bbox="395 1171 1311 1503"> <thead> <tr> <th>Grade</th> <th>Criteria</th> </tr> </thead> <tbody> <tr> <td>0</td> <td>Awareness of sensation on the soles of feet; no muscle weakness or visible impairment.</td> </tr> <tr> <td>1</td> <td>At least 2 points on the foot where touch is not felt and/or muscle weakness is present (on testing) but there is no high stepping gait when the patient walks and there is no other visible impairment.</td> </tr> <tr> <td>2</td> <td>Visible impairment of the foot if it has occurred since the onset of loss of sensation and / or loss of muscle function due to leprosy. High stepping gait when the patient walks (obvious foot drop).</td> </tr> </tbody> </table>	Grade	Criteria	0	No severe visual impairment (can count fingers at 6 meters; visual acuity > 6:60). No visible impairments. Normal blink reflex.	1	Loss of blink reflex and/or inability to hold the eyelids closed against moderate force to open them. No severe visual impairment (can count fingers at 6 meters - visual acuity > 6:60).	2	Visible impairments to the eye, severe visual impairment (cannot count fingers at 6 meters - visual acuity < 6:60) and/or any other visible damage to the eye (regardless of cause).	Grade	Criteria	0	Touch is felt on the palm of the hand; no muscle weakness or visible impairment.	1	At least 2 points on the hand where touch is not felt And/or muscle weakness is present on testing, but there is no visible impairment.	2	Visible impairment of the hand if it has occurred since the onset of loss of sensation and/or loss of muscle function due to leprosy.	Grade	Criteria	0	Awareness of sensation on the soles of feet; no muscle weakness or visible impairment.	1	At least 2 points on the foot where touch is not felt and/or muscle weakness is present (on testing) but there is no high stepping gait when the patient walks and there is no other visible impairment.	2	Visible impairment of the foot if it has occurred since the onset of loss of sensation and / or loss of muscle function due to leprosy. High stepping gait when the patient walks (obvious foot drop).
Grade	Criteria																								
0	No severe visual impairment (can count fingers at 6 meters; visual acuity > 6:60). No visible impairments. Normal blink reflex.																								
1	Loss of blink reflex and/or inability to hold the eyelids closed against moderate force to open them. No severe visual impairment (can count fingers at 6 meters - visual acuity > 6:60).																								
2	Visible impairments to the eye, severe visual impairment (cannot count fingers at 6 meters - visual acuity < 6:60) and/or any other visible damage to the eye (regardless of cause).																								
Grade	Criteria																								
0	Touch is felt on the palm of the hand; no muscle weakness or visible impairment.																								
1	At least 2 points on the hand where touch is not felt And/or muscle weakness is present on testing, but there is no visible impairment.																								
2	Visible impairment of the hand if it has occurred since the onset of loss of sensation and/or loss of muscle function due to leprosy.																								
Grade	Criteria																								
0	Awareness of sensation on the soles of feet; no muscle weakness or visible impairment.																								
1	At least 2 points on the foot where touch is not felt and/or muscle weakness is present (on testing) but there is no high stepping gait when the patient walks and there is no other visible impairment.																								
2	Visible impairment of the foot if it has occurred since the onset of loss of sensation and / or loss of muscle function due to leprosy. High stepping gait when the patient walks (obvious foot drop).																								
<p>EHF score</p>	<p>The EHF score is calculated from data already being recorded routinely. It is the sum of all the individual disability grades for the two eyes, two hands and two feet. Since the disability grade can be scored as either 0, 1 or 2, it follows that the EHF score ranges from 0 to 12. A score of 12 would indicate grade-2 disability of both eyes, both hands and both feet.</p> <p>The EHF score has been shown to be more sensitive to change over time than the disability grade itself. The simplest way to use the EHF score to measure the development of new or additional disability during MDT is to calculate the score at diagnosis (this examination is already done in the initial assessment of the disability grade) and then repeat the examination at the time treatment is completed. The two scores can then be compared.</p>																								

Sensory testing of hands and feet	<p>Sensory testing of hands and feet should be done at the time of diagnosis and periodically during treatment (MDT) and after treatment in order to detect evidence of nerve damage as early as possible. Monofilaments for sensory testing are the method of choice for testing sensations of hand and feet, but a very light touch with a ball pen can be used if monofilaments are not available.</p> <p>✓ if the person has sensation at that place. X if the person does not have sensation at that place.</p>																											
Voluntary muscle test (VMT)	<p>When you test the strength of a muscle, write down the result as: (S) Strong when the strength seems normal. (W) Weak when the strength is definitely reduced. (P) Paralyzed when there is no strength left to produce the movement you are testing. Above mentioned is a simple VMT grading but MRC 5 point grading (can also be used for higher standards).</p> <table border="1" data-bbox="395 860 1321 1167"> <thead> <tr> <th colspan="2">MUSCLE GRADE</th> <th rowspan="2">RANGE OF MOTION</th> <th rowspan="2">RESISTANCE</th> </tr> <tr> <th>SWP Scale</th> <th>MRC Scale</th> </tr> </thead> <tbody> <tr> <td>Strong</td> <td>5</td> <td>Complete</td> <td>Full</td> </tr> <tr> <td rowspan="4">Weak</td> <td>4</td> <td>Complete</td> <td>Reduced</td> </tr> <tr> <td>3</td> <td>Complete</td> <td>None</td> </tr> <tr> <td>2</td> <td>Reduced</td> <td>None</td> </tr> <tr> <td>1</td> <td>Muscle flicker</td> <td>None</td> </tr> <tr> <td>Paralyzed</td> <td>0</td> <td>None</td> <td>None</td> </tr> </tbody> </table>	MUSCLE GRADE		RANGE OF MOTION	RESISTANCE	SWP Scale	MRC Scale	Strong	5	Complete	Full	Weak	4	Complete	Reduced	3	Complete	None	2	Reduced	None	1	Muscle flicker	None	Paralyzed	0	None	None
MUSCLE GRADE		RANGE OF MOTION	RESISTANCE																									
SWP Scale	MRC Scale																											
Strong	5	Complete	Full																									
Weak	4	Complete	Reduced																									
	3	Complete	None																									
	2	Reduced	None																									
	1	Muscle flicker	None																									
Paralyzed	0	None	None																									

Relapse	<p>Relapse is defined as the re-occurrence of the disease at any time after the completion of a full course of treatment with WHO recommended MDT. Relapse is diagnosed by the appearance of definite new skin lesions and/or an increase in the bacterial index) of two or more units at any single site compared to BI taken from the same site at the previous examination. Care should be taken to exclude patients suffering from leprosy reactions.</p>
----------------	---

DIAGRAMATIC CODES USED IN CHARTING LESIONS SEEN IN LEPROSY		
1		Hypopigmentation
2		Residual hypopigmentation
3		Anaesthesia
4		Hypoesthesia
5		Well defined skin-lesion
6		Fine infiltration
7		Marked infiltration
8		Nodules

9		Nerve thickening
10		Nerve abscess
11		Thickening of ear margins
12		Foot drop / wrist drop
13		Gynaecotheilia
14		Gynaecomastia
15		Plantar ulcer scar

16	Sparse eye brows	
17	Loss of eye brows	
18	Collapse of nose	
19	Loss / absorption of digits	
20	Flexion deformity of fingers and toes	

Abbreviations:

BI - Bacterial index

EHF - Eyes, Hands, Feet

HIV/ AIDS - Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome

ILEP - The International Federation of Anti-Leprosy Associations

LPN - Lateral popliteal nerve

MB - Multibacilliary leprosy

MDT - Multidrug therapy

MRC - Medical Research Council

PB - Paucibacilliary leprosy

PT - Posterior tibial nerve

SWP - Strong, Weak, Paralyzed

VMT - Voluntary muscle test

WHO - World Health Organization