

Leprosy in Hong Kong: From Hay Ling Chau to Cheung Sha Wan

The problem of leprosy in Hong Kong could be dated back to the post war period in 1940's. At that time, the socio-economic and environmental conditions in the society were far from satisfactory. In the late 1940's, with the influx of immigrants from Mainland China, the number of patients suffering from leprosy in Hong Kong increased significantly.

In 1950, the Hong Kong Government and the Leprosy Mission London decided to set up a leprosarium to provide shelter and treatment to these patients. A small uninhabited island east of Lantau Island called "Ni Ku" (meaning Nun) Island was chosen. Dr. Neil Duncan Fraser, an experienced leprologist, came to Hong Kong from China with his nursing team to begin their holy mission of building up the leprosarium in August 1951. One could only imagine the enormous difficulties of the task, considering that the island was totally deserted without any means of transport or communication, neither was there any water nor electricity supply. In 1954, the Governor, Sir Alexander Grantham announced the official opening of the Leprosarium in the island. The island was renamed as "Hay Ling Chau" (HLC), which derived from the word "healing" and carried the meaning of an "island of joyful soul". At that time, all leprosy patients were compulsorily admitted into HLC for isolation and treatment. The leprosarium at one time had a maximum intake of 540 patients in the early 1960's.

With the use of dapsone, the control of leprosy had made a step forward. Between 1960's to 70's, the network of Special Skin Clinics distributed throughout the territories worked closely with HLC leprosarium in taking care of patients, mostly non-infectious tuberculoid ones, as outpatients. These patients could remain at homes under dapsone treatment and compulsory isolation was no longer required.

In 1970, Dr. N. R. Honey, a specialist in tropical disease, joined the Department and dedicated to leprosy patients care. With the effort of the whole leprosy team, the number of new patients and in-patients declined steadily. HLC leprosarium was closed down and about 50 crippled in-patients were relocated into the new Lai Chi Kok Hospital in 1974.

Another hallmark in our fight against leprosy in Hong Kong was the introduction of WHO multidrug therapy (MDT) in 1980's. Most of the active patients could be taken care as outpatient in the Kowloon Hospital Special Skin Clinic. By 1990's, the number of new patients had decreased dramatically, from around 25 per month in the 1960's to approximately one to two new patients per month. And the new case detection rate has remained low ever since (0.15 per 100,000 population in 2001). Hong Kong has officially declared the successful elimination of leprosy when the prevalence rate of leprosy fell well below 1 per 10,000 population in mid 1980's. In 2000, the operation of Special Skin Clinic was relocated from Kowloon Hospital to the current venue at Cheung Sha Wan. In addition, I have the honour to witness the discharge of the last leprosy in-patient from the Princess Margaret Hospital this year.

Looking ahead, the challenges which we are facing in our battle against leprosy in this new millennium are of two folds. First is the continuous task in keeping check on the reservoir of active and relapse-prone patients in the community. This is done, on the one hand, by closely monitoring and adequately treating those active cases so as to rendering them non-infectious. On the other hand, we are regularly following up and keeping surveillance on the few thousands inactive lepromatous case for any sign of early relapse and to treat the late sequel arising from the disease.

As the disease is becoming rarer in the community, the second challenge that we face nowadays is the tendency towards late presentation and diagnosis in our new patients. Both the patients' awareness and the physicians' index of suspicion on leprosy are decreasing with time. As the center of excellence in leprosy, the Social Hygiene Service will continue to shoulder the responsibilities, not only in patient management, but also in physician training and public education of this aged disease in the years to come.

Dr. K. H. Lau