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THE PRESENT SITUATION OF ENDEMIC TREPONEMATOSES (YAWS AND PINTA)
IN THE REGION OF THE AMERICAS

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Introduction

Until the first half of this century, yaws and pinta represented an important public health problem in several countries in Latin America and the Caribbean (e.g. Haiti, Jamaica, Mexico, Colombia, Suriname, etc.)

With the advent of penicillin therapy it was possible to eliminate or eradicate pinta and yaws in most of the endemic areas through mass campaigns coordinated by WHO/PAHO during the 1950's and 1960's.

Unfortunately, pockets of the two endemic treponematoses still exist in some countries, namely in rural areas.

In order to assess the present situation of yaws and pinta, visits of one week duration were planned to Suriname, Guyana, Venezuela, Colombia, Panama, Mexico (State of Michoacan and Oaxaca*, and Brazil (Belém - State of Pará). Because of logistical problems and recent reports of yaws in rural areas of Haiti, Haiti was visited instead of Colombia.

Main Objective

The main objective of these exploratory visits was to assess the situation of the endemic treponematoses through epidemiological analysis (number of patients according to sex, age, geographical origin, estimates of seroprevalence and trends) and a description of national control programs.

Activities

During the months of July and August 1988 the following activities were undertaken in the countries visited:

- Review of available statistical data in all countries.
- Discussions with health personnel responsible for the dermatology clinics or general practitioners at health centers.

It was not possible to visit the remote areas in which cases are now occurring, because sufficient time was not allotted for the trips.

Recommendations (See also specific country reports)

Suriname

This year, a "Bush Negro" patient from the interior of Suriname was diagnosed with clinical recent yaws in Paramaribo. Because of guerrilla warfare activity in this area no survey could be done, but this should be attempted in the areas in which the "Bush Negro" live, once travel to the interior is safe.

* The initial plan was to visit Guerrero and Chiapas and the changes were made by the Ministry of Health in Mexico.

Guyana

The 36 cases of yaws diagnosed at the leprosy clinic in Georgetown in the period from 1979 to 1984 indicate that a survey should be planned for Guyana. It is also necessary to investigate pinta among Indians living on the border with Venezuela.

Venezuela

According to all the information obtained, yaws has been eradicated from Venezuela.

There is a great possibility of endemic pockets of pinta persisting among Indians tribes living in the Territory of Amazon and in the South of the state of Bolívar.

Because of the difficulties in reaching these areas, experienced field health personnel responsible for malaria and leprosy control should be involved in the planning and implementation of activities for the eradication of pinta.

Panama

According to all the information obtained, yaws has been eradicated and pinta was never confirmed in Panama.

In spite of this, yaws should be investigated in rural populations living on the border with Colombia.

Haiti

There is no information available to analyze the present situation of yaws and even the small foci of pinta, but according to a short-term consultant epidemiologist in Haiti, active cases of yaws are still occurring in rural areas of the South.

A yaws survey of the district of Jeremie should be a top priority.

Mexico

In spite of the well organized campaigns, cases of active pinta are still being reported in one of the states visited - Oaxaca.

Active case finding seems to be necessary in at least 3 or 4 of the previous endemic states in order to eradicate the disease.

Yaws has never been diagnosed in Mexico.

In general, if additional financial support could be obtained, longer well planned missions (2-3 weeks each) should be carried out initially in Guyana, Haiti, Suriname, and Colombia, to conduct clinical and laboratory evaluations (including serological surveys) in populations living in suspected endemic areas. Health authorities should be made aware of the need to train and use health personnel working in remote areas in other health programs (e.g. malaria, leprosy, leishmaniasis) to detect cases of pinta and yaws in the remaining countries where these endemic treponematoses are still suspected to occur. Mass treatment of cases and contacts with penicillin as required, should then be carried out to eradicate yaws and pinta from the Americas.

Suriname

Period of visit: 12-14 July, 1988.

Activities:

- 12 July The first day we were able to visit the Department of Dermatology and the Pan American Health Organization Representation.
- 13 July In the morning, we were able to discuss matters relating to the main skin diseases that are seen in the clinic, particularly relating to yaws and pinta patients. In the afternoon, along with Dr. S. Sadal (Chief of the Department of Dermatology) we were able to visit a health center in Groningen, 60 Kms. from Paramaribo. Here we were able to interview selected health center personnel, and the Director.
- 14 July We visited the Department of Dermatology of the School of Medicine and discussed the most prevalent skin diseases in the country. We also visited the Medical Mission, which does public health services primarily among Amerindians and Bush negroes (persons of African ancestry who are descendants from escaped slaves who inhabited the interior of the Eastern coastal regions of South America).
- 15 July Departure to Georgetown, Guyana

General information about yaws and pinta in Suriname.

As is well known, yaws was a highly endemic treponematosi s in Suriname in the past. After the penicillin campaign and repeated mass surveys, very few patients have been recorded. According to information obtained from Dr. Sadal (Annex 1) positive serology ranged from 1.33% in the Nickerie District to 41.12% in the Malobi District. In the period covering 1976 to 1980, a total of 6,507 school children were examined, and serologically tested (VDRL and TPHA) in some cases). Of these 667 (10.2% were VDRL positive and 40 of these patients had titers of up to 1/16.

In most of these VDRL positive school children there were no clinical signs of yaws.

According to the dermatologists from Paramaribo interviewed (from the Ministry of Health and the School of Medicine), very few patients with clinical yaws have been seen in the past 8 years. This year a case of clinical lesions of early yaws was found in a Bush negro.

It is important to note that the Surinamese dermatologists know yaws, can recognize the disease and are concerned about it.

The dermatologists working for the Ministry of Health goes to the interior of the country on a regular basis for Leprosy control and simultaneously takes care of the other skin diseases.

Examinations of Amerindians and Bush negroes by general practitioners working for the Catholic Missions were conducted until recent years. Of 3,381 blood samples collected from patients examined, 579 (17%) were VDRL positive.

Health service infrastructure has deteriorated in the past two years due to the war situation, primarily in the areas of Bushn egros. Health care services have also been very irregular during this period. Local health personnel are concerned that yaws could again become a problem if the situation continues.

Conclusions

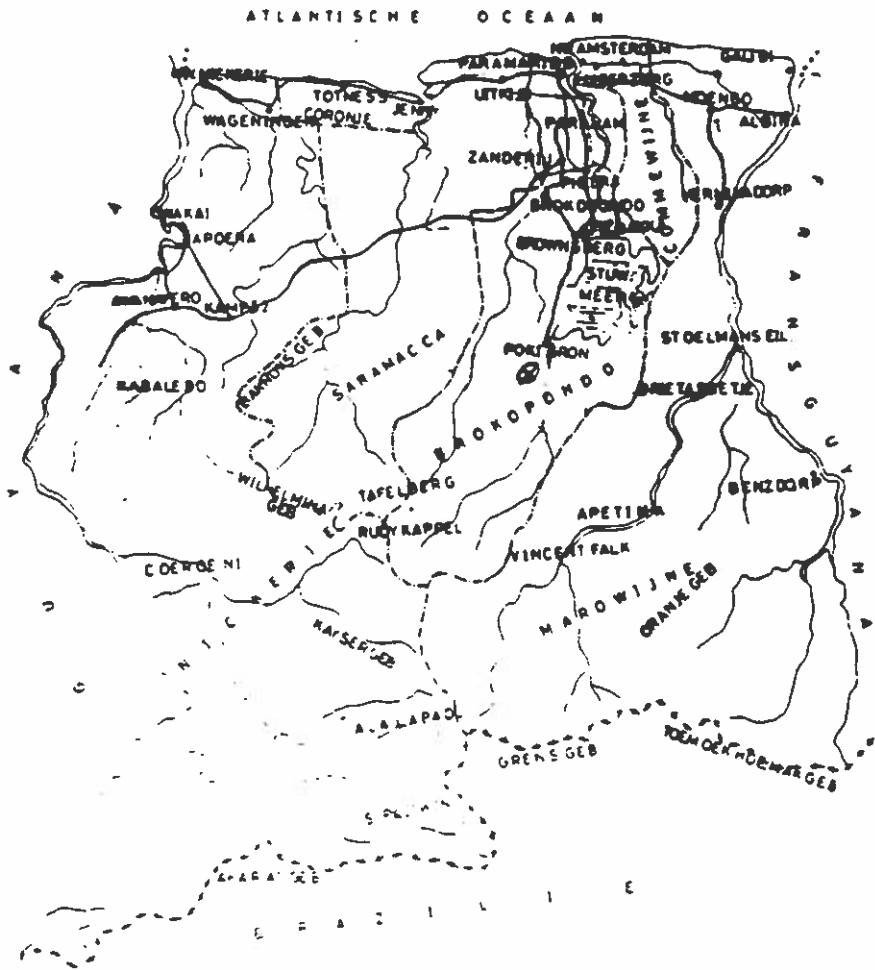
1. According to the information obtained, a high incidence of low titer positive serology in some districts could be explained by the existence of latent cases of yaws, or residual serology after penicillin treatment.
2. There is no information on venereal syphilis in the interior, even though it is high in urban areas, particularly in Paramaribo.
3. Very few cases of clinical yaws have been seen in the past eight years.
4. No endemic area of pinta is known in the country.
5. Due to the war situation it was impossible to visit areas of Amerindians and Bush negros.

Recommendations

1. An exhaustive clinical examination of the Bush negro population should be undertaken after the war.
2. There should be a clinical examination of Amerindians living in remote areas.

KAART VAN SURINAME

ANNEX I



Guyana Period of visit: 15-21 July, 1988.

Activities:

- 15 July Visit to the PAHO Representation.
- 19 July We visited the Chief Medical Officer at the Ministry of Health.
- 20 July Interview with Dr. Ruth B. Huntley, Chief of Leprosy Control Program and Responsible for Leishmaniases.
- 21 July Visit to Dr. Lopez, a Cuban dermatologist working for the Ministry of Health since October 1987. He is the only dermatologist working in the country.

Interview with Dr. K. Carter, responsible for the Malaria Control Program.

Visit to Paika, a health center about 30 Kms. from Georgetown.

General information about yaws and pinta

Yaws

With the exception of 36 cases of yaws diagnosed in the leprosy clinic by Dr. R.B. Huntley and Dr. Patricia Rose, during the period from 1979 to 1984, there was no more information about the situation of yaws in the country. Also, I could not find any published paper and history about yaws campaigns.

The previously mentioned 36 cases of yaws were confirmed through clinical aspects and VDRL, according to the information provided by Dr. Huntley. All these cases were diagnosed in the area of Georgetown and Parika. Most of the patients were children and two were adults; the VDRL varied from 1/4 to 1/256 and in 28 patients the VDRL was over 1/6 and it was negative in three patients (Annex 1).

Conclusions

1. There is very little information about the situation of yaws in the country.
2. There is no information about pinta.

Recommendation

1. A yaws survey should be planned for Guyana.

Observation

There was no opportunity to visit areas in the interior due to lack of transportation.

"SPIROCHAETAL YAWS" (P.H.C.)

Georgetown - Guyana
1979 - 1984



No.	NAME	AGE	SEX	RACE	YEAR
1	DR	12	M	I	(12/10/79) (23/11/79)
2	FM	15	M	I	(13/07/79) (23/11/79)
3	ES	41	F	I	(16/01/80) (06/02/80)
4	BS	12	M	I	(11/01/80) (08/07/80)
5	SG	14	M	A	(11/02/80) (08/07/80)
6	EG	12	F	A	(11/02/80) (08/07/80)
7	MB	5	F	A	(25/02/80) (08/07/80)
8	YM	7	F	I	(18/03/80) (08/07/80)
9	SC	9	M	I	(18/01/80) (08/07/80)
10	DL	35	M	I	(03/11/80) (24/11/80)
11	SD	8	F	I	(09/01/81) (20/01/81)
12	LF	12	M	M	(13/02/81) (18/02/81)
13	LP	10	M	I	(13/05/81) (20/05/81)
14	YA	4	M	I	(28/05/81) (03/06/81)
15	SC	4	M	A	(11/08/81) (21/08/81)
16	KC	6	F	I	(14/07/81) (21/08/81)
17	TS	3	M	I	(11/08/81) (31/08/81)
18	SK	10	M	A	(11/08/81) (31/08/81)
19	SC	7	M	M	(08/09/81) (16/10/81)
20	DC	6	M	M	(08/09/81) (16/10/81)

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