

NEWSLETTER FROM KIYOSE



No. 5, August 1992

The Research Institute of Tuberculosis, JATA
3-1-24 Matsuyama, Kiyose-shi Tokyo 204 Japan

30th Anniversary of International Training Courses Celebrated

Treasure of Exceeding a Thousand Participants Worldwide

The 30th anniversary of international tuberculosis training courses was celebrated on May 21, 1992 at Chinzanso Hotel in Tokyo. It was organized as a part of the 43rd National TB Convention by Japan Anti-TB Association (JATA) in collaboration with the Ministry of Health and Welfare and JICA. In the presence of *Her Imperial Highness Princess Chichibu*, the Patroness of JATA, the opening ceremony and memorial symposium were conducted. The main aim was to give wider publicity on the importance of the TB international courses in Japan to politicians, top government officers, opinion leaders, and the general public, so that the achievements of the courses at RIT would be highly appraised, shared with other agencies, and the courses should be continued.

Congratulatory addresses were given by Mr. H. Endo of JICA Board, Dr. H. Sawamura of Ministry of Health and Welfare, and Dr. J. W. Lee of Western Pacific Regional Office of WHO. These 3 organizations have been major supporters of the courses behind RIT.



Her Imperial Highness Princess Chichibu



Dr. J. W. Lee

Special appreciation note was given to contributors; Dr. T. Iwasaki, initiator and promoter of the international courses since 29 years ago and various organizations which had accepted the group visit for more than 10 years, including Akita Prefecture Women's Anti-TB Society.



Ex-participants Actively Working All Over the World

The international TB training courses started at RIT in 1963 and the participants have numbered 1016 persons from 66 countries by March 1992. This number is really a treasure not only of RIT or Japan, but also of the world. The major courses are 1) group training course in TB control (4 months, 525 participants since 1963), 2) group training course in tuberculosis control for administrative medical officers (so called advanced course; 6 weeks, 218 participants since 1973), 3) group training course in laboratory works for tuberculosis control (4 months, 126 participants since 1975). There have been various individual courses (100 participants since 1969). There was a course for chest surgery with 47 participants from 1965 to 1974.

According to the survey by RIT, nearly 70% of the participants of the courses are still actively working for TB services and 20% working at higher positions in each government. Two became the Minister of Health in their respective countries.

Man Power Development Is Key for TB Control

Presided by *Dr.M.Aoki*, 8 speakers participated in the panel discussion from various stand points on above title.

Ex-participant guests: *Dr. Victor Yamamoto* (participant in 1976 and 1985, Ex-Health Minister of Peru) and *Dr. Lorita Cruz* (1974 and 1978, Chief of Plans and Program of TB Control Services, Philippines) gave special talks on how their training benefited in developing TB programme in their countries. They also participated in the workshop in the advanced course. *Professor P. Chaulet* (Vice-chairman of executive committee of IUATLD, lecturer for the advanced course) talked the importance of the training programme for the TB personnel in the worldwide fight against TB. He appraised the role of Tokyo course among all courses in the world. *Dr.A. Kochi* (Chief Medical Officer of TB Unit, WHO, Geneva, also an ex-participant) stressed to intensify the training in administrative skills and follow up programme. *Mr.R.Suwa* (Director of Training Division, JICA) talked about recent move for strengthening training scheme in JICA, especially of the third world trainings (satellite courses) and network making of the ex-participants.

Dr. N.Sakai (Director of Communicable Disease Control, MOHW) talked about the benefit of promoting international TB training in Japan.

Dr. N. Ishikawa explained to the audience about what had been done during the courses; in the class room, in the field visits, and the follow up programmes. He stressed that training should be a life long programme to each participant. *Dr. T. Shimao* summarized the discussion stressing the importance of the face to face relationship with the trainees and appealed to the agencies and people concerned to support the international TB training courses continuously.



Dr. V. Yamamoto



Dr. L. Cruz



Professor P. Chaulet

INTERNATIONAL TB TRAINING COURSE IN THE WORLD



Man cannot be Made in a Day

The late *Dr.H.Kumabe*, ex-Director of RIT and greatest pioneer TB specialists in Japan, had started a domestic training course just after the 2nd World War. It was a time when tuberculosis had been furiously prevalent and the economic situation was terribly poor in Japan. He used to stress that "Drugs and equipments can be made available soon, but human resources cannot be made quickly".

Finally its is worth mentioning that the workshop was a great success in that it has clearly demonstrated to the audience including decision makers, the historical achievements and the perspective of the Tokyo course in the world fight against tuberculosis.

Photo Display... The photographs and snaps of the activities carried out during the international training courses for the past 30 years were displayed in the lobby of the hotel, attracting the audience and participants to the historical pathway at a glance. Buildings were so old and Dr. so and so looked so young, for example, *Dr.Iwasaki* and other teachers in their younger expressions !



EURO	Turkey	20
4 countries	United Kingdom	1
[23	Netherlands	1
ex-participants]	Germany	1

EMRO	Ethiopia	16
12 [222]	Iraq	13
Egypt	Sudan	13
Afghanistan	Somalia	9
Yemen	Kuwait	1
Pakistan	Saudi Arabia	1
Iran	Syria	1

SEARO	India	40
8 [330]	Bangladesh	32
Indonesia	Myanmar	27
Thailand	Sri Lanka	7
Nepal	Bhutan	1

WPRO	Papua New Guinea	9
18 [281]	Macao	3
Philippines	Laos	3
Japan	Cambodia	2
China	Fiji	2
Korea S.	Hong Kong	2
Malaysia	Micronesia	2
Viet Nam	Western Samoa	1
Singapore	Palau	1
Taiwan	Marshall Is.	1

AFRO	Zambia	3
12 [67]	Malawi	3
Tanzania	Guinea	1
Kenya	Sierra Leone	1
Nigeria	Swaziland	1
Liberia	Senegal	1
Uganda	Mozambique	1

AMRO	El Salvador	5
12 [105]	Haiti	4
Brazil	Argentina	2
Bolivia	Nicaragua	2
Peru	Mexico	1
Paraguay	U.S.A.	1
Colombia	Chile	1

66 countries, 1028 ex-participants
INTERNATIONAL TRAINING COURSES
1963 - June, 1992

- 1: Dr. A. Rouillon, Former Executive Director of IUATLD, is giving a lecture. (1981)
- 2: Listening to Dr. Shimao
- 3: Practicing under the direction of Dr. Takase. (1963)
- 4: Dr. Aoki and participants. (1963)
- 5: Dr. Iwasaki is watching participant's work. (1963)



Name list of international TB training course published

The name list of ex-participants and lecturers (1963 - the year course started - to 1991) has been printed. The 34-pages booklet lists names and addresses according to country with an index by course and year.

It will be sent to readers free on request, Please write to the editor with your latest data if any change. Any information or requests to the editor about the Newsletter are also welcome.

For the 30th Anniversary of the International Training Course

Nearly 20 years have passed since I had a chance to follow the TB Control Course in 1972 and Advanced Course in 1973 after attending the 22nd International Anti-Tuberculosis Conference in Tokyo. I still have a vivid memory of where I lived, where I read books and where I did experiments at RIT. I still remember the friendly members of RIT and our teachers who taught us basic lessons about technique and organization in a TB control programme.

My classmates and I were asked to visit and exchange experience in the daily work of our TB Control programme network at commune, district and province level with those in Japan, Korea and Hong Kong. What we have learned helps us much in implementing the TB control programme in our countries.

Basic TB control methods have not changed much in developing countries, but ambulatory treatment under supervision and short course chemotherapy have been added. Thus doing my daily work usually reminds me of what I learned 20 years ago.

The organizers of international training course in TB control at RIT as well as the teachers of this course in the past 20 years have held high positions and have contributed much to the TB control programme of the world through WHO and IUATLD and they directly helped us with their information issued at International Anti-TB Conference.

I hope I have a chance to visit RIT again to get more knowledge and to make the TB Control Pro-

gramme in my country more effective.

On the 30th anniversary of the international training course at RIT, I wish all the organizers and members good health to be able to hold the International course in TB control programme to help developing countries at least for the next 2-3 decades.

Dr. Le-Ba. Tung, VIETNAM ('73A, '72C)



Participants with Dr. Iwasaki (Control Course in 1972)

The Newsletter brought me sweet memories of my stay in Japan. It was a memorable and fruitful event in my life and career.

After my retirement from the government service as a state TB control officer, I am working as a specialist in "Medical Relief Gas

Victims Project" at Bhopal, which is being run by the Indian Red Cross Society. This project is providing medical relief to MIC gas victims of Bhopal. As you know, the tragedy occurred on the night of December 2 and 3, 1984 on account of toxic gas leak from the Union Carbide plant. I was also one of those very seriously affected by the toxic gas exposure.

I am also an Honorary Secretary of the M.P. State TB Association and Hon. Project Director of TB Institute "Kamla Nehru Kshaya Sansthan" which is a project undertaken by our association and is still in the infancy stage.

I am glad to note that the 30th anniversary of the international training course is being celebrated in May, 1992. I send all my good wishes for the success of the event.

Dr. Dharam Prakash Verma, INDIA ('69C)

OUR ACTIVITIES

Clinical Research Division

We do clinical studies for tuberculosis and non tuberculous pulmonary diseases. We have recently researched on the prognosis of patients with smear positive culture negative sputum and chemotherapy of diabetic pulmonary TB.

In Japan, the standard regimens for pulmonary TB are 6HRS(or E)/3HR to cavitory or sputum positive

cases while 6HR to non-cavitory and smear negative cases. Pyrazinamide has not been used in standard regimens because of its side effects, especially of liver dysfunction. But we think that 6 months chemotherapy is better than the standard regimens. We are now studying the 6 months short course chemotherapy with 2HRSZ(or E)/4HR.

We are also investigating on the usefulness of serum anti-TDM (trehalose - 6, - 6' - dimycolate) titer for diagnosis of pulmonary TB.

-Dr. M. Wada, Division Chief

Thailand Conducted 3rd TB Prevalence Survey in 1991

The 3rd TB prevalence survey was conducted in Thailand in 1991, whose examination coverage was 75.9%. The report says that the prevalence rate (>10 yr) was 0.92% by chest X-ray, and 0.19% by sputum examination (direct smear and culture). An English version of the Report will be available soon. (Cont'd to page 7)

Announcement

Newsletter from Kiyose introduced a new column "Attention to my activities". Articles pertaining to any interesting activities which you are now planning, or carrying out are accepted.

Please send your article to the editor within 1/2 printed page, including tables, figures or photographs, if any.

More Active Leadership Requested

National Symposium on International Medical Cooperation

Symposium on International Medical Cooperation was held on February 6, 1992 in Tokyo sponsored by the Mainichi Newspapers and JATA with an audience of more than 300 people. It appealed to the public about Japan's important role in the international medical cooperation, and especially focused on tuberculosis control.

Seven panelists, who represent the related fields, including Drs. M.Aoki, N.Ishikawa, A.Kochi, Chief of Medical Officer of TB Unit, WHO, presented their issues and discussed actively through 2 sessions themed "Current situation and issues in Japan" "What Japan can do for tuberculosis control" - in the international medical cooperation.



It was pointed out that a shortage of qualified Japanese specialists who can work abroad is one of the serious obstacles. Dr. Ishikawa stressed that every cooperation should be done according to each nation's circumstances. A strong request for including drug-management system into JICA TB Control Project was made. Dr. Kochi requested Japan to take a more active leadership, putting its great deal of experience into good use.

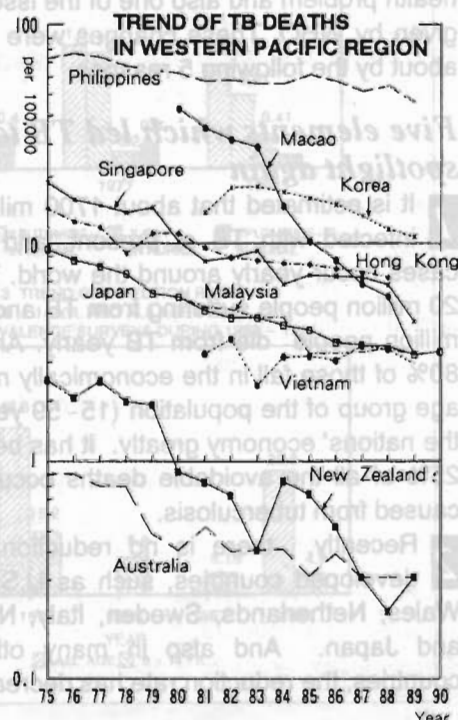
TB Workshops, Thailand

Two days domestic workshop on integration of TB control into PHC was held in March 1992 at the ASEAN Institute for Health Development(AIHD), Salaya in the outskirts of Bangkok. The workshop was organized jointly by AIHD of Mahidol University, TB Division of MOH, and RIT, Tokyo. It aimed to summarize and analyse the current situation of TB control at PHC level in Thailand. Though the integration has been on progress and statistically more than 80 % of all registered patients are treated at provincial and district general hospitals, the role of district hospitals, health centres, or health volunteers has not yet been clear and they differ from place to place. Various further studies including operational action research at district level have been planned.

In February 1993, an international workshop will be held at AIHD to discuss the perspectives of the integration of TB control in PHC in Asia. Participants will be invited from Asian countries to talk on their achievements and problems of the integration of TB control in their respective countries.

International Tuberculosis Information Centre (ITIC), RIT

The ITIC has been set up in RIT since April 1992. It aims to collect and disseminate the information on tuberculosis around the world, particularly in Asia. This includes epidemiology and control programme of tuberculosis in each country, updated technical information on tuberculosis control and the human resources data bank for tuberculosis. TB information network is being developed so far in the Western Pacific Region in collaboration with WHO/WPRO. The latest information book will soon be published. Participants are requested to provide RIT with any information on tuberculosis in their respective areas.



“TB Control is Most Cost - Effective Intervention Available Today”

from Lecture by Director-General of WHO

Dr. Hiroshi Nakajima, Director-General of WHO, spoke for a special lecture themed “The global situation in lung health” in the 67th Annual Meeting of Japanese Society for Tuberculosis which was held on April 16 and 17 in Hiroshima, Japan.



Dr. Nakajima, Director-General of WHO

The following is the summaries of a part of his lecture.

Tuberculosis tended to be given less priority for the past two decades although it has been a major problem. However, after great changes in the situation during the last two or three years, TB now becomes the center of attention in the international health problem and also one of the issues with priority given by WHO. These changes were mainly brought about by the following 5 reasons.

Five elements which led TB to the spotlight again

1 It is estimated that about 1700 million people are infected with TB at present, and 8 million new cases occur yearly around the world. There are over 20 million people suffering from TB and out of them, 3 million people die from TB yearly. And the fact that 80% of those fall in the economically most productive age group of the population (15-59 years) damages the nations' economy greatly. It has been proved that 25% of all the avoidable deaths occurred are those caused from tuberculosis.

2 Recently, there is no reduction in TB in the developed countries, such as U.S.A., England & Wales, Netherlands, Sweden, Italy, Norway, French and Japan. And also in many other developed countries, the reduction rate has decreased.

3 Spread of HIV infection make TB problem more serious and complicated. It is estimated that 4 million people are infected with both TB bacilli and HIV and 78% occur in Africa at present.

4 Thanks to a rapid progress in biotechnology and immunology, we can expect great progress in diagnosis, treatment and prevention of TB.

TB control is most cost-effective intervention available today

5 The cure rate of TB patients was successfully improved by introducing 8 months short-course chemotherapy even in such countries, where the health infra-structure is premature, as Tanzania, Nicaragua, Malawi and Mozambique. It proved that this kind of TB control can be the most cost-effective intervention available today in the nations under the similar conditions.

WHO has launched a TB control strategy to solve the problems by the end of this century. The aim of the strategy is to achieve the target of 85 % cure of TB patients under treatment and 60% detection of sputum-positive patients. It has been proved that it can be achieved even in the developing countries with poor health infra-structure and low income.

However, it can be successfully achieved only when people involved in the TB control cooperate intensely with each other and each country establishes its own national TB control programme. WHO is doing its best to lead TB control projects in the world now.

- M. Aoki

“Our dream be true”

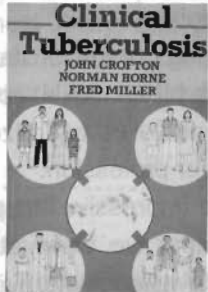
Dr. Nakajima and myself were classmates in high school and we shared the room at the school dormitory. Many years have passed and our positions are quite different now, though, I am very glad to learn that he has the same dream of activating tuberculosis control programme around the world as I. We are fortunate that he was declared as Director-General of WHO and that WHO gave one of the highest priorities on tuberculosis control programme in this lecture. I hope that our dream comes true.

CLINICAL TUBERCULOSIS

by
J.Crofton, N.Horne and F.Miller

London, MACMILLAN EDUCATION LTD, 1992,
pp.210, £14.99

The co-authors of this new guide on diagnosis and treatment of tuberculosis are Sir John Crofton, Drs. Norman Horne and Fred Miller (U.K.), who are well known experts in tuberculosis and respiratory diseases all over the world. The book is intended to be used as a manual by clinicians working in areas where sophisticated laboratory facilities are unavailable, and is described always in association with the national tuberculosis programme of developing countries in simple English.



It is composed of 6 chapters, general background to clinical tuberculosis, tuberculosis in children, pulmonary tuberculosis in adults, non-pulmonary tuberculosis in adults, tuberculosis, HIV infection and Aids, and treatment of tuberculosis, in appendices, details of drug use, surgery in tuberculosis, chemoprophylaxis, infections with opportunistic mycobacteria, tuberculin testing, and gastric suction and laryngeal swabbing in children are added, and readers will find out answers to any possible questions raised during daily practice. Many illustrations and tables will help you understand the contents.

A low cost edition of this book is available for developing countries thanks to financial support arranged through TALC and from the IUATLD. If you are interested in the book, please contact the following addresses.

TALC (Teaching Aids at Low Cost) IUATLD
P.O.Box 49 68 Boulevard Saint-Michel
St Albans 75006
Herts Paris, 6me
AL1 4AX France
U.K.

- T. Shimao

Continued from page 5

TB PREVALENCE SURVEY IN THAILAND, 1991

This survey covered 5 regions (northern, eastern, central, northern-eastern, southern) of the country. Total examinees were 39,803 and the examination coverage was 75.95%.

The prevalence rate (>10 yr) is 0.92% by chest X-ray, and 0.19% by sputum examination (direct smear and culture). Both of them are lower than those in 1962 and 1977. (Fig.1)

This survey, however, shows that among the urban population the prevalence rate of sputum positive is higher than one in 1977. (Fig.2)

The survey shows the prevalence of infection is 29.8% in all age (30.20% in urban area, 29.71% in rural area), 4.93% in 0-14 yr population (4.01%, 5.07%). In 1977, it was 40.6% (39.0%, 41.4%) and 15.2% (14.6%, 15.9%), respectively. (Fig.3) The BCG coverage rate (<4yr) is 74.4% (78.5% in urban

area, 73.7% in rural area) in 1991. It was 61.4% (62.6%, 60.2%) in 1987.

Information from Dr. Tavisak, Thailand (Summarized by N. Yamada)

Fig. 2 TREND OF TB PREVALENCE FROM 3 PREVALENCE SURVEYS DURING 1962 - 1991 IN URBAN AND RURAL

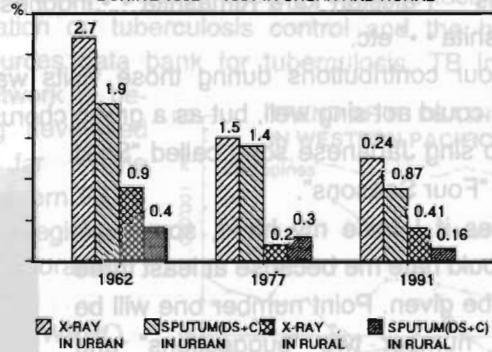


Fig. 3 TREND OF INFECTION RATE IN 0 - 14 YR. AND ALL AGE FROM 5 PREVALENCE SURVEYS DURING 1962 - 1991

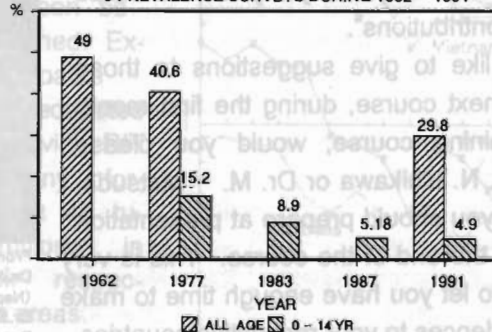
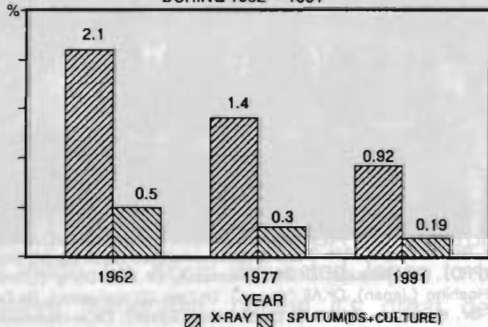


Fig. 1 TREND OF TB PREVALENCE FROM 3 PREVALENCE SURVEYS DURING 1962 - 1991



**Minasan Konnichiwa,
Ogenki desuka!**

We were in Japan from June 10 to Oct. 14, 1991 for Group Training Course in Tuberculosis Control.

During our fruitful stay, we gained a lot of knowledge about tuberculosis control and epidemiology which will enable us to utilize it at our respected countries and our profession.

The impressive hospitality at Japan gave the feelings that we were at our homes with our families whenever and wherever specially during homestay.

We also visited to SONY Audiovisual System, Kiyose Museum, Health Centre, Ministry of Health and Social Welfare, Saitama Public Health Summit and last but not the least, Royal Highness Princess Chichibu. Kiyose Museum is for the first time gave invitation to foreigner participants.

We are very thankful and kind regards for Japan Anti-Tuberculosis Association, Branches of Akita, Aomori, Morioka, Niigata, Sado Islands, Mayors, Governors' wife (Ms.Sasaki Ai Ko), JICA staff, JATA staff, JATA's president, and the shiny stars of RIT in Kiyose.

- L - Land of Niigata, Sado, Tohoku,
- O - Ocean of Japan
- V - Valley of Gotemba
- E - Everlasting memory of AIMM (Aoki, Ishikawa, Matsuda & Mochida)

JA MATA ! *Dr. Taj Mohammad, Pakistan*



Participant's comment

I was a "Mr. Contributions" !

I like staying in Japan because during 106 days resided in RIT Dormitory at Kiyose - shi, I felt just like in my home village siregarmatogu Tapanuli, Indonesia. And most of the Japanese food are "oishi desu", especially Tempura and shabu-shabu.

Cooking is an art business to be practised during the TB training at RIT to avoid homesickness. At 12:00 to 1:00 p.m. usually you may find "traffic jam" in the dormitory kitchen.

The study rips were very interesting. But remember and please try to express in different ways, if you want to avoid monotone "personal introduction" like these expressions - "Pakistan kara Kimashita • • ,Indonesia kara Kimashita • • " etc.

One of our contributions during those visits was "singing". I could not sing well, but as a group chorus, we used to sing Japanese song called "Shiki No Uta" or "Four Seasons".

Sometimes if I raise my hand, some colleagues would hate me because at least three points will be given. Point number one will be "question", number two "suggestions" and number three will be "contribution". It consumed times. That is why my friends called me "Mr. Contributions".

I would like to give suggestions to those attending next course, during the first month of the training course, would you please contact Dr. N. Ishikawa or Dr. M. Matsuda, what data you should prepare at presentation session at the end of the course. This is very important to let you have enough time to make correspondences to your respective countries.

Dr. Loekman Hakim Siregar, Indonesia



From left : 1st row - Mr. Prasai (Nepal), Ms. Zama (Japan), Ms. Vado (Nicaragua), Ms. Levy (Peru), Dr. Aoki, Dr. Garvez (WPRO), Dr. Matsuda, Dr. Ha (Vietnam), Dr. Xiao-Dong (China), Dr. Komal (Nepal); 2nd row - Dr. Hoshino (Japan), Dr. Ali (Yemen), Dr. Lam (El Salvador), Dr. Taj (Pakistan), Dr. Siregar (Indonesia), Dr. Kwanjana (Malawi), Dr. El Dabh (Egypt), Dr. Al-Hammadi; 3rd row - Dr. Mustafa (Turkey), Dr. Mishra (Nepal), Dr. Perera (Sri Lanka), Dr. Somsak (Thailand), Dr. Sichone (Zambia), Dr. Fujita (Japan)

The Last Report of our Group

PURPOSE: *To may live together with our dear friend, TB bacilli*



Ms. Huang
(China)



Ms. Yamakami
(Japan)



Mr. Kayastha
(Nepal)



Ms. Kudoh
(Japan)

Ms. Sameera
(Yemen)



Ms Sriyani
(Sri lanka)



Mr. Somsak
(Thailand)



Ms. Manik
(Indonesia)



Ms. Nohra
(Colombia)

MATERIAL: *9 strains from 8 countries*

PROCESS:

- ① Select strains from developing countries grown on different media
- ② Pretest them by Japanese language for 3 weeks at HITC to get "Konnichiwa", "Ohayo gozaimasu", "Arigato", "Ikura desu ka?" etc.
- ③ Transfer them from HITC to Kiyose dormitory
- ④ Incubate them for 3.5 months in RIT
- ⑤ Sometimes concentrate them by centrifuging with manual making, microteaching and examination
- ⑥ Observe them every weekend in "Akihabara", "Ueno", "Ikebukuro" etc...

RESULT:

- ① Some strains from tropical media such as Thailand, Sri Lanka and Indonesia are strong enough to grow in lower temperature even in the snow. They must be "*Low temperature resistant strain*".
- ② One strain from Colombia must be kept at a stable temperature because this strain has much energy and hence exothermic. So when you stain it, should not heat. This is a "*Cold staining method required strain*".
- ③ One strain from Nepal can absorb much alcohol but never be disordered by alcohol. It is called "*Alcohol fast bacilli - AFB*".
- ④ One strain from Yemen needs special treatment to obtain visible growth. This strain can grow well on vegetable and fish added medium but not meat added medium. This type of strain is usually a "*Semi-synthetic growth - positive strain*".
- ⑤ Two of them can't be stained by Japanese society even if they are grown originally in Japan. They must be "*mutant strain*".
- ⑥ One strain is difficult to distinguish from Japanese strains morphologically, but it can be easily identified because it shows "*PCR(Probably Chinese Reaction) test - positive*".

CONCLUSION:

- ① All strains are well grown by good teachers and showed eogenic and smooth growth after 3.5 months incubation of RIT.
- ② Each strain has different colour. Some strains are very active and bright in day time and others at night time. They are called Photochromogens and scotochromogens respectively.
- ③ All strains must be incubated in their own countries for one year and should be checked if they are at dormant stage or not by action plan.
- ④ There are still bacteriologically unclassified strains in some parts but they were registered into FUJIKI FILE as her precious strains.

New Guidelines of Chemotherapy Regimens by WHO

Reviewer : M. Aoki

The Tuberculosis Unit of the World Health Organization published "Guidelines for Tuberculosis Treatment in Adults and Children in National Tuberculosis Programme" in September 1991. The 23-pages document, the summary of hot and long discussions in a workshop held in Geneva in July 1991, is full of important information on chemotherapy of tuberculosis today.

Here are three particularly important points.

Tuberculosis cases to be treated are divided into 4 categories according to the site of disease, history of prior tuberculosis therapy and the results of bacteriological examinations (Table 1). It is natural that the highest priority is given to category I and II, but it is important to note that pulmonary smear negative tuberculosis with limited parenchymal involvement is included in the cases to be treated. An important part of category III (smear negative TB) is tuberculosis in children and young persons. Higher (but not the highest) priority is given to pulmonary tuberculosis of this category since a proportion of these patients will become smear positive, if not treated.

GUIDELINES FOR TUBERCULOSIS TREATMENT IN ADULTS AND CHILDREN IN NATIONAL TUBERCULOSIS PROGRAMME (WHO/TUB/91.161)

– Contents –

Chapter	I Introduction
	II Standardization of short course chemotherapy Case-definition, Essential drugs, Choice of regimens
	III Patient monitoring
	IV Patient adherence
	V HIV infection and tuberculosis
	VI Programme effectiveness and programme objectives
	VII Quality control of tuberculosis drugs
Annex 1	Essential antituberculosis drugs
Annex 2	Management of hypersensitivity to drugs
Annex 3	UNICEF pricelist of essential antituberculosis drugs
Annex 4	1991 cost in US\$ of suitable regimens of chemotherapy for tuberculosis in National Control Programme

Table 1 DEFINITION OF EACH CATEGORY OF TUBERCULOSIS

Category	Definition
I	1) New cases of AFB smear positive pulmonary tuberculosis 2) Newly diagnosed seriously ill patient with severe forms of tuberculosis
II	Relapse and failure smear positive tuberculosis patients
III	1) Pulmonary smear negative tuberculosis with limited parenchymal involvement 2) Extra pulmonary tuberculosis other than the clinical forms considered in Category I
IV	Chronic tuberculosis

Table 2 NEWLY RECOMMENDED REGIMENS OF CHEMOTHERAPY BY WHO

Category	Priority	Regimens	Cost*
I New smear positive Severe cases	Highest	2HRZE/4HR	52
		2HRZE/4H ₃ R ₃	39
		2HRZE/6HE	38
		2HRZE/6HT	29
II Relapse, Failure	Highest	2HRZES/1HRZE/5H ₃ R ₃ E ₃	76
		2HRZES/1HRZE/5HRE	79
III New smear negative Extra pulmonary	Higher Low	2HRZ/2HR	35.5
		2HRZ/2H ₃ R ₃	28.5
		2H ₃ R ₃ Z ₃ /2H ₃ R ₃	16.5
		2HRZ/6HE	43
		2HRZ/6HT	25
IV Chronic cases	Low	Second line drugs	-

* in US \$

Short course chemotherapy is recommended as standard chemotherapy in a National Tuberculosis Programme even in developing countries. The recommended regimens of chemotherapy and their cost are shown in Table 2. Since the costs of drugs vary from day to day and place to place, the cost shown in Table 2 is to be used just for comparison of each regimen. The cost was calculated as the sum of the cost of each drug, and not of combined ones which is widely used recently. Regimens for smear negative cases are also short course chemotherapy, but its duration is four

months only. It is worth mentioning that the cost of eight months treatment with 2HRZ/6HT is much more expensive than that of 2H₃R₃Z₃/2H₃R₃.

Hospitalization or fully supervised ambulatory administration of drugs during the initial phase is advised, to achieve nearly 100% pa-

tient's adherence. However, specific strategies should be determined according to the situation.

Letter from

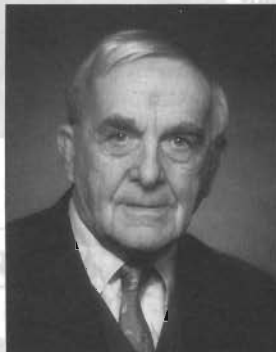
Dr. Stefan Grzybowski

I do not exactly know how many times I have visited Kiyose in order to participate in teaching the training course participants. I think it was about seventeen times -

This course was difficult to teach since both the level of the understanding of English and the knowledge of medicine differed greatly among participants. As far as English was concerned, quite early on I learned that the best way to assess it, is to tell a simple joke and to observe how many participants and which ones are laughing. If the majority were not laughing, then it was necessary to speak much more slowly and in more simple language.

The teacher's task was made much easier by two excellent course coordinators, the late Dr.H.T.Lin and his successor Dr. Umemura, and it is fitting that we should pay tribute to their work. Dr. Lin was a great personal friend who I came to know first when he worked in Korea. I had met Dr.Umemura before, as well, when he introduced me to a whole group of dancers who tried to teach me the art of Nepali dancing in a rather attractive bar in a small town in Nepal. From the way they treated Dr.Umemura, I thought that he was likely the chief director of the whole troupe.

There were two mistakes which I made during my early visit to Kiyose. The first was to tell my Japanese hosts exactly when I would arrive in Tokyo and by which plane. The result was that they very kindly sent a limousine to the airport and it took at least seven hours to get to Kiyose; during the trip, I wanted to go to the bathroom and it was very, very difficult to ask the driver to stop at a suitable place. I think the institute paid more for this service than my monthly salary in rich Canada. Subsequently, I learned how to travel by appropriate trains and I could reach Kiyose in 2- 1/2 hours with very little hardship. My second mistake was to stay in a hotel in Tokyo. This involved a lot of travelling every day and a lot of expenditures. I have done it only once and subsequently, I enjoyed-- really



enjoyed-- with the participants in the Dormitory. This was the old dormitory and wasn't the most luxurious accommodation I have stayed in, but it was great fun. I did not have the opportunity of staying in

the new one. I really enjoyed staying with the participants in the old dormitory.

I remember once I had a room with a balcony on the second floor. This was probably in August because there was a lot of dancing around a pole and I met a lovely nurse who showed me the steps and kindly invited me to visit her in her little apartment in the nurses' residence. We listened to music and on the second occasion I was rather late in leaving her apartment. I found the door to the dormitory firmly locked. However, I knew where a rather long ladder was kept. I quickly found it and climbed to the place where I found a main door from inside, and I took the ladder back to the place. I was very careful to observe that I was not seen by anyone and imagine my great surprise the next morning when Dr. Shimao, who was the director at the time, laughed at my escapades with the ladder. I developed a new respect for the secret service run by the institute.

I made many Japanese friends. I was particularly honoured to work a bit with that great scholar, Dr. Iwasaki, and to have earned a lasting close friendship with Dr. Shimao who has done so much for the tuberculosis problem internationally. Last but not the least, it was a great pleasure to meet the participants from all the corners of the world and to develop close relationships with them. With many of them, I still correspond.

My best wishes to the members of the Institute, visiting lecturers and all the participants.

Stefan Grzybowski

Dr. Stefan Grzybowski, Canada
Lecturer for TB Control Course and Advanced Course
(1972 - 1988)

Obituary

Ms. Sachiko Takeda of Administration Dept. of RIT died of cancer on December 18, 1991. She was aged 59.

Ms. Takeda had supported International Training Course with her efficient clerical ability since the first Tuberculosis Control Course with 7 participants in 1963. With her friendly personality, she also had been a great help to make participants' life in Kiyose more comfortable. When the 22nd IUAT World Conference was held in 1972 in Tokyo, she contributed to its success as a member of its secretariat. She visited ex-participants in Philippines, Indonesia and Thailand in a follow-up team in 1989.



◇ Staff Overseas Visit ◇

Expecting the children to realize my dream

Ms. M. Ohmori, Epidemiology Div.

I attended the TSRU meeting which was held in Geneva, March 18-19, 1991. This was my first trip to Europe. As everyone knows, ladies are always fond of clothes. Nevertheless, before my leaving, I was so busy that I did not have enough time to prepare for my trip, especially clothes. Concerned about my miserable clothes, the lady staff members in Epidemiology Div. brought their coats, skirts and so

on for me for the formal occasions. Finally, my fashion was perfect, as even my husband mistook me for another lady. However, oh my God! When I reached there, I realized that my formal shoes were left in my house. It all happened because I was putting on my casual shoes to be more comfortable in the plane.



Anyway, the TSRU meeting was a success. My presentation in the meeting was on "Estimating the Year of Eradication of Tuberculosis in Japan". I estimated that the year would be 2058. However, what a pity, I won't be living then, to make sure of my study result.

In Europe, I saw a lot of children. Maybe I was looking at them unconsciously, remembering my two small kids left in Japan. All the children I met there were so cute and so lovely. I took a lot of pictures of them. I wish those children will realize my dream - the eradication of tuberculosis.

JICA TB Control Project Launches in the Philippines

Japan International Cooperation Agency (JICA) will start a new TB project in Public Health from September 1992 in the Philippines in cooperation with the Philippines Government. Sebu province has been selected as the Project site. RIT is fully involved in the project and Dr. M. Suchi of Epidemiology Dept. will be assigned as a team leader.

One of the main aims of the project is to establish a reference laboratory system for AFB and its term is planned for 5 years. There are another two TB Control Projects conducted by JICA, which involve RIT staff, going on in Nepal and Yemen.

Individual Training Course

The following people took training courses individually:

- Mr. G. S. S. Hassani from Yemen
(Basic Laboratory Works /Sept.25 - Oct.17, 1991)
- Dr. Prakash Mishra from Nepal
(TB Control Method /June 19 - Oct. 11, 1991)
- Dr. M. K. Prasa from Nepal
(Chest Radiology /Oct.12 - Dec.20, 1991)
- Ms. Leela Rai from Nepal
(Public Health Nursing in TB Control Programme /Oct.28, 1991 - March 26, 1992)
- Mr. A. B. Al Hammadi from Yemen
(Health Education /Sep.1, 1991 - May 29, 1992)
- Dr. G. M. Bajracharya from Nepal
(Management of Clinical Laboratory Services /Jan.16 - 24, 1992)
- Dr. Huang Zi Qing from China
(TB Laboratory Works /Feb.8 - 29, 1992)
- Dr. Kedar Basnet Chhetri from Nepal
(Advanced Radiological Technology /Nov.1991 - June 1992)

Staff News

Welcome:

- Dr. T. Umino (Pathology Div.)
- Dr. S. Sakamoto (Pathology Div.)
- Dr. A. Hayashi (Epidemiology Div.)
- Dr. S. Kyogoku (Epidemiology Div.)
- Dr. M. Suchi (Epidemiology Div.)
- Dr. N. Yamada (International cooperation Dept.)
- Mr. T. Watanabe (Administration Dept.)
- Mr. T. Yoshida (Administration Dept.)

Farewell:

- Dr. K. Iwai (Pathology Div.)
- Dr. T. Sakai (Pathology Div.)
- Mr. M. Oda (Administration Dept.)
- Mr. T. Suzuki (Administration Dept.)
- Mr. S. Tanaka (Administration Dept.)
- Mr. T. Sato (Administration Dept.) moved to Head Office
- Mr. M. Fujino (Clinical Div.) moved to Fukujiji Hospital

Announcement

A name list of ex-participants and lecturers has been published. (For application, see page 4)

Your news and voices are always welcome!

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