spinosa, C. carvi, H. rhomboideus, M. sativa, M. longifolia, O. vulgare, R. webbianum, S. lappa and is biochemically rich in aloin (0.82 mg/100 g), carvone (4.7 mg/100 g), thymol (8.0 mg/100 g), t-anethole (7.3 mg/100 g) and menthol. The usefulness of this appetizer is because of its medicinal properties like its digestive and laxative efficacy and appetite enhancement.

The natural resources in Ladakh Himalayas are very limited and will not be available for long term use without scientific and sustainable utilization. The wild species depend upon the good amount of snowfall because of an acute scarcity of water on the barren mountains. Only a few species are cultivated by farmers. However, long-term exploitation from natural habitat, illegal trade, unscientific collection, grazing by domestic and wild animals, herbivores, seed predators, Himalayan rabbit, marmot, Blue sheep and Himalayan mouses or Pyka (Ochotona roylei) remain high threats to the wild resources in the extreme heights of the cold desert. Presently most of the valuable species are on the verge of extinction due to continuous exploitation over a long time. Conservation of high altitude plant resources through ex situ and in situ conservation is now being initiated by Government agencies, NGOs and local farmers.


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MEETING REPORT

Self help and low cost, integrated treatment of lymphatic filariasis for rural communities*

According to a recent WHO estimate, there are a billion people at risk of getting lymphatic filariasis (LF) in about 80 countries. Over 120 million have already been affected by it, and over 40 million of these are seriously incapacitated and disfigured by the disease. India is the worst-affected country as one third of the people infected with the disease live here. LF is grouped under ‘neglected disease’ as it affects people living in poorest conditions and no research is undertaken on such disease. Even the drugs for the neglected disease initiative (www.dndi.org) have not given any priority to the development of any treatment for LF. A morbidity control agenda of the Global Alliance for the Elimination of Lymphatic Filariasis (GAELF) is in its infancy. A clinical management trials working group of GAELF recommended exploring the current practices of skin care in filariasis-endemic areas and evaluation of effectiveness of traditional methods for lymphedema treatment. The Institute of Applied Dermatology (IAD) developed a self-help, low-cost and integrated treatment by combining ayurveda, yoga therapy and biomedicine on a pathophysiological basis derived from biomedicine. This research was mentored by T. J. Ryan (Department of Dermatology, Oxford Medical School) and was conducted as an extramural project of Kerala State Council for Science, Technology and Environment (KSCSTE), Thiruvananthapuram during 2004–05. Both the Indian Council for Medical Research (ICMR), New Delhi and KSCSTE supported the peer review of this treatment protocol (pilot study) during the First National Seminar on ‘Evidence-based and Integrated Medicine for Lymphatic Filariasis, other Chronic Dermatoses and HIV/AIDS’ during February 2005. Later the International Society of Lymphology awarded its President’s prize to this study during the 20th International Congress of Lymphology held in Brazil (2005) and ICMR discussed this protocol in the Medical Development Congress (2006). Fifteen Indian states are endemic for LF and estimated 1.7 crore population is disabled. Against this background, the Second National Seminar was held during 14–16 February 2007.

Raghunath (Sir Dorabji Tata Centre for Research in Tropical Diseases, Bangalore) delivered the keynote address on ‘Filarial worms in India and pathogenesis of lymphatic filariasis’. This was followed by presentation of 46 patients as the representative population of 354 lymphedematous patients who received integrated treatment. Patients of all stages of primary and secondary lymphedema, who were performing this self-help treatment from 15 days to 3 years, participated in this 3 h session. Each patient’s base line and follow-up photographs and clinical data
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![Figure 1. Result after two years of self-help and integrated treatment in lymphatic filariasis patient.](image)

were displayed on the screen. Peers and delegates examined the patients and interacted with them to know their experience of taking integrated treatment. Patients narrated their experience and how they felt before and after the treatment. Later patients themselves demonstrated all stages of the self-help integrated treatment protocol, namely water-wash using acidic soap, phanta soaking, pre-Indian manual lymph drainage yoga exercises to drain the central lymphatic, inguinal and popliteal nodal lymph drainage, Indian manual lymph drainage (ayurvedic skin care also called Udvarthana or Vimlapana), compression using long stretch bandages with special emphasis on de-kinking of lymphatic and post Indian manual lymph drainage yoga exercises. The discussion followed the demonstration focused on whether treatment empowerment of the patients is possible by transfer of the know-how of self-help integrated treatment from patients to patients with a little technical support from a local Ayurvedic doctor and nurse,paramedic. Later Muralidhar Sharma (SDM Ayurveda College, Udupi) spoke on how to select the herbal oils and skin care medicines based on local clinical features using a simple table developed by the IAD that can be used in the field conditions.

In his speech on ‘Lymphatic filariasis: The neglected disease of the Indian poor’, P. K. Sumodan (Government College, Vadakara quoting NVBDCP, New Delhi) presented the statistics that the number of microfilaremia carriers in India is estimated to be 31.6 million. There are 20.5 million chronic cases with 7.5 lymphedema cases and 13 million hydrocele cases. Bihar has the highest endemicity (over 17%) followed by Kerala (15.7%) and Uttar Pradesh (14.6%). Andhra Pradesh and Tamil Nadu have about 10% endemicity. Goa showed the lowest endemicity (less than 1%) followed by Lakshadweep (1.8%), Madhya Pradesh (above 3%) and Assam (above 5%). He traced the descriptions of the disease from the 6th century BC, in ayurveda in Susrutha Samhitha and that discovery of microfilaria (mf) in the peripheral blood of patients was made for the first time by Lewis in 1872 in Calcutta.

In the next session, Preethi on behalf of S. K. Shelly (Radiologist, Apollo Hospital, Chennai) gave a presentation on the techniques of performing lymphoscintigraphy and how this investigative procedure could be adopted to qualify and quantify the outcomes of any treatment for lymphoedema. The paper narrated that lymphoscintigraphy could be a useful tool to know how the integrated treatment of LF developed by the IAD is achieving the lymph drainage. Later Muralidharan (CPCRI, Kasaragod) in his talk on ‘Repeated measurements on patients treated for lymphoedematous limbs: Database management and analysis’ demonstrated the new database created jointly by the IAD and his department to store the data of lymphoedema patients. Using the SPSS software, data entered in a format could be analysed within minutes. In the session on research methodology on reverse pharmacology, T. J. Ryan talked on ‘The nature and need for evidence’, he emphasized that RCT, although the best, is not the only method to evaluate the evidence for efficacy. Particularly in traditional medicine, other forms of evidence have to be considered. Pran Manohar (AVTAR, Coimbatore) explained the new programme they are implementing with the Central Council for Research in Ayurveda and Siddha, New Delhi. The programme entitled RUDRA (Random Uninterrupted Documentation for Retrospective Analysis) is the uniform case sheet for ayurvedic institutions. ‘The theory of reverse pharmacology: Application to ayurvedic medicine’ was discussed by Ashwin Kumar Raut (ICMR Centre of Excellence in Reverse Pharmacology, Mumbai). Pradeep Kumar (Resource person, ICMR) spoke on how to obtain informed consent from patients as statutory requirement for conducting clinical trials.

On the third day Christine Moffatt (Editor of Journal of Lymphedema, London) in her keynote address on ‘International perspective – west and east learning together’ compared the similarities between the best practice of Europe and that of the integrated regimen for filarial lymphoedema. She hoped that international projects would be collaboration between the UK lymphoedema project, European industry and the IAD in India to improve patient care for any kind of lymphoedema. Later, one hour was devoted to examine and discuss six patients who were considered poor responders in integrated management. The experts emphasized the importance of the end point of satisfaction of the patients as well rather than clinical response. Often much of the reversible oedema was reduced and what remained was actually fat tissue accumulated after chronic oedema. How-
ever, biomedical experts advocated invasive liposuction as the only possible remedy. Ayurvedic experts had many non-invasive oral treatments to offer.

Other topics discussed included the quality of life assessment in ayurveda, methods to improve twak prasadana (health of skin) in ayurveda and free papers on Vitiligo and HIV/AIDS. S. Jamal made a presentation on how he managed filarial lymphoedema using nodo-venous shunts. He said that a combination of nodo-venous shunt and integrated treatment would give faster results. Regina Foster (Foldi Clinic, Germany) gave 4 h of demonstration, spread over 3 days, on how to treat lymphoedema using Foldi’s technique. In her talk on Foldi technique, she felt that integrated management of filarial lymphoedema is almost similar to Foldi’s technique but being implemented in a more difficult clinical background.


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**Thankful, or thankless?**

_Srinivas Bhogle_

On the eve of his retirement as NAL’s Director in 2002, I asked T. S. Prahall what fraction of his time as Director he spent ‘usefully’1. I expected him to say ‘about 50%’, but he surprised me by replying ‘25%’ in all seriousness.

This was about five years ago. I wonder what directors in CSIR, DRDO and other publicly-funded national establishments feel today. It would be no surprise if today’s figure was well below 25%.

In fact, we are rapidly heading towards a situation where a capable scientist, researcher or professor would rather not accept a leadership role. This is very worrying because it leaves the door open for an incompetent individual to take charge, and eventually seriously hurt the institution.

Why are the best now unwilling to accept leadership roles? Why has a once coveted job suddenly become thankless? We will try to list the inhibiting factors, but in no particular order.

_You really can not do much:_ The director of a national R&D establishment is severely shackled. He might step in with many ideas and a grand vision, but he is, day after day, told by the ‘administration’ that the rules do not permit Action A, Action B… or, indeed, any intelligent action. The director has to be really brave to stick to his resolve over long periods of time; most eventually succumb, or mellow to permissible levels.

_There is no worthwhile enabling infrastructure:_ It is a common misconception that the director’s post is very powerful; much is made of the director’s ‘powers’ and his enormous ‘delegated authority’. In reality, this does not add up to much. The director might sanction expenditure, but his power to take a large sum of money and spend it, or sign a purchase file, is limited. The director might intervene only to push the file. The truth is that the director can only be effective if he has a good enabling infrastructure and he is usually saddled instead with an abysmal support system.

_No effective power:_ The accepted management wisdom is that a good leader cleverly juggles between the carrot and the stick. The director of a national lab or institute however quickly discovers that a stick will take him nowhere: if he orders his administrative office to act in a certain way, the office will silently refuse to act and nothing will happen.

The mundane overwhelms the magnificent: Over the years, most national labs have become too director-centric. The director must apparently be involved in everything: clearing most administrative files, approving air travel by a private airline for an ‘ineligible’ colleague, or presiding over every farewell party to greet a retiring colleague (as institutions age, retirements are multiplying). Sometimes it is the nature of the director’s personality that compels him to get so intimately involved in mundane activity, but usually it is something more sinister: everyone’s passing the buck, and the buck stops with the director. If it is the sort of file that will set an auditor’s or vigilance officer’s eyeballs rolling, the administration will ‘protect’ itself by seeking the director’s signature.

_The best are going away:_ One of the great joys of leading an R&D establishment is to work with intelligent colleagues to create great knowledge and technologies. This was always hard in a national lab because of the poor enabling environment, but it may now become impossible as talented scientists, lured by high salaries and better work conditions, leave in large numbers and new talent refuses to come in. How is the director to work his magic in such circumstances?

_Endure nonsense from bureaucrats:_ Directors, especially new and weak directors, must also reckon with the severe pressures that they face from the bureaucrats at the HQ. The Delhi bosses love to