The British Association of Plastic Surgeons (2003) **56**, 522–523

BJPS
An International Journal of Surgical Reconstruction
www.bjps.com

EDITORIAL

Noma: should we care?

In Western countries public authorities keep records of their citizens. They start at birth and end at death. During their lifetimes these citizens contribute to many nationwide registers in all kind of domains, including public health. These registrations have been subject to international standardisation for more than a century, resulting in the International Classification of Diseases of the World Health Organization (WHO). Code A69.0 refers to: Necrotising Ulcerative Stomatitis (Cancrum oris, Fusospirochaetal gangrene, Noma, Stomatitis gangrenosa). This does not mean that all patients in the world that die from noma appear in global mortality statistics. On the contrary, there seems to be a historical rule that a society only starts to register its dead when it is able to feed all its inhabitants sufficiently.[1] In large areas in the world, like the sub-Sahara savannah, where extreme poverty and famine are common, we do not have even an approximate idea about mortality rates and causes of death. The WHO recognises this problem in contradictory ways. It does not mention noma as an important cause of death in its yearly reports because good statistical data about its incidence are lacking. At the same time it has taken an initiative to bring noma to the attention of the world of public health, mentioning an estimated yearly incidence of noma in the world of 140 000 cases.[2] How these estimations have been made is unclear.

Recently new and more apposite data have become available from the International Noma Project (a plastic surgical rehabilitation program) in Sokoto, Nigeria.[3] They result paradoxically, from a failure in communication. The local Haussa language lacks adequate medical terminology so that, at the beginning of the project patients have been called up to come to the hospital by broadcasting and promoting free operative treatment for people with 'a hole in their face'. This resulted in the appearance of not one but two categories of patients: survivors of noma and patients with cleft lip. Epidemiological data of 235 cleft lip and 378 noma patients, operated by 16 consecutive medical teams in Sokoto, have been analysed and compared with the incidence of cleft lip. Taking into consideration the mortality of noma ($\pm$90%), the incidence of noma in north-west Nigeria could be estimated as 6.4 per 1000 children. Extrapolation of this incidence to the countries bordering the Sahara gives an incidence of noma of 25 600 and a global incidence of 30 000–40 000. This indicates that noma plays a clear but minor role in child mortality in the world, exactly as it did one and a half century ago in Europe, when in Amsterdam, with a child mortality of 50%, noma only accounted for half a percentage of this death rate.[4] Nevertheless the global mortality due to noma would be comparable with that due to diseases like trypanosomiasis, leishmaniasis, acute upper respiratory infection, obstructed labour and appendicitis.[5]

These vast numbers hide another important consideration, that of the numerous individuals that do not die of noma, but survive it by some miraculous quirk of fate. They are not part of any registration or official estimation, but are condemned to an ostracised life, often hidden in a loam hut. Should we care about them?

The International Noma Project in Sokoto, Nigeria is located in a well equipped hospital, where since 1996 many medical teams from The Netherlands, Germany and France have worked for a couple of weeks each year. The British support of the project has so far been mainly financial in the form of grants from the charity Facing Africa. Surgical engagement and support for the project from the UK would be very welcome.

References

1. Marck KW. Noma, het ware gezicht van echte armoede. Alphen aan den Rijn: Belvédère/Medidact, 2001;97.

doi:10.1016/S0007-1226(03)00226-1

2. Bourgeois DM, Leclercq MH. The World Health Organization initiative on noma. *Oral Dis* 1999;**5**:172—4.
3. Fieger A, Marck KW, Busch R, Schmidt A. An estimation of the incidence of noma in north-west Nigeria. *Trop Med Int Health* 2003;**5**:402—7.
4. Scheltema Beduin L. De sterfte in Amsterdam gedurende 1854—1865. *Ned Tijdschr Geneesk* 1868;**12**:399—435.
5. The World Health Report 2001.

K.W. Marck
De Pôlle 24, 9084 BT
Goutum, The Netherlands
E-mail address: kwmarck@knmg.nl

Klaas W. Marck is chairman of the Dutch Noma Foundation, a sister organisation of Facing Africa, that supports the Noma Project in Sokoto, Nigeria (see www.facingafrica.co.uk).