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Letters to the Editor

Professor Pattyn's paper, "Comments on the Chemotherapy of Leprosy as Influenced by Present Knowledge of *Mycobacterium leprae*" (*Leprosy Review* (1972) **43**, 126) is an excellent summary of our present knowledge of the treatment of leprosy, and in no sense do I mean to underrate the excellence of his presentation. However, one comment needs to be made on the subject of the treatment of leprosy. Dr Pattyn deals with the treatment of the *disease,* but I suggest we need to consider primarily the treatment of the *patient.* Our ultimate aim is to induce a state of health and well-being in the *patient,* and it is only for that reason that we attempt to kill and eradicate *Myco. leprae.*

Dr Pattyn discusses the host–parasite relation where the host response is poor, e.g. lepromatous leprosy; however, the majority of leprosy patients do not have this form of leprosy: they have at least a partial cell-mediated immunity (CMI). Nor does he take into consideration the very important fact that wherever significant disease exists, damage to nerves is always present. He states that "there is no need to change the existing dosage of 600 mg of dapsone per week for mass campaigns", although in tuberculoid leprosy "lower doses of dapsone ($\frac{1}{10}$ of the standard dose) could be adequate". And he does not take into consideration the stimulation of CMI that occurs during treatment, especially in patients suffering from BB or BT leprosy. This response may be reduced by smaller doses of dapsone than those usually recommended; it can be reduced even more by the use of other drugs.

By all means, the best chemotheraphy regime must be found and followed, but the actual need of the patients is the first and overriding consideration: elimination of disease should not leave the patient with a permanent iatrogenic nerve deficit.

The best result is attained by the suppression of CMI with corticosteroids while treating the leprosy with clofazimine. The individual response to this therapy is often quite unpredictable; both the duration of treatment and size of dosage needed therefore vary tremendously. In early nerve damage, adequate doses of corticosteroid should be used to control nerve pain and infiltration. Clofazimine should be initially used in doses of 400 to 600 mg daily, and reduced gradually as the activity of the disease diminishes. Eventually, after 6 months to 2 years, dapsone can be introduced.

Dramatic reversal of paralysis and anaesthesia may be attained whenever the disease is active; but if lesions are no longer infiltrated and there is no clinical evidence of activity in nerves, the prognosis for recovery of nerve function is poor. In the majority of patients, clinical activity is determined easily, but one group of patients with BT near BB leprosy have large, slightly infiltrated and markedly hypopigmented skin lesions, with little nerve pain or infiltration, yet actual nerve damage may be extensive and still active. In this group response to this kind of management will be striking.

The threat of disability following permanent anaesthesia and paralysis in

borderline leprosy is so important that this treatment is worth trying in any patient who appears to have even doubtfully active nerve involvement. Surely the retention or restoration of some nerve function is better than a lifetime of disability.

Our preliminary evaluation of this regime indicates that when the process in the nerves is active, at least 50% of distal sensory and motor deficit is reversible. It is urgent that our scientific efforts be mounted to aid this most important group of patients with borderline leprosy so as to establish without question the best treatment and management.

In treating the *disease*, let us not forget the *patient*.

Nigeria ROY E. PFALTZGRAFF

Dr Pfaltzgraff's letter was shown to Professor S. R. Pattyn, who replies as follows:

The main purpose of my paper was to show that techniques are now available that permit the rational interpretation of the antibacterial therapy of leprosy. The most urgent need now is, on the basis of laboratory evidence (experimental chemotherapy), to determine what are the best treatment schemes that necessarily take into account all relevant factors, such as the cost of different drugs and their administration, the possibility of controlling treatment, the reactions of the patients in terms of toxicity or other complications, etc., what I would like to call the "over-all acceptability". All these can be scientifically measured only in controlled clinical trials.

From a microbiological point of view, patients with multi-bacillary leprosy constitute a different challenge to antimicrobial therapy from those with paucibacillary forms of the disease. Independent studies will therefore have to be conducted on different types of leprosy.

In the meantime, while it is possible that individual patients may benefit from treatment with very high doses of clofazimine associated with corticosteroids, as proposed by Dr Pfaltzgraff, it is very doubtful if such a treatment, because of its high cost, can be applied on any large scale at present.

Antwerp, Belgium S. R. PATTYN

I am very pleased to announce that vacancies will exist from 1 September for 6-months' residency appointments at A L E R T, in the following departments:

(1) Clinical Leprology.
(2) Reconstructive Surgery of Leprosy.
(3) Leprosy Control.

You will appreciate that these appointments offer a very good opportunity indeed for young men wishing to work overseas to obtain an introduction to Africa, as well as to leprosy. In addition, it will provide A L E R T with staff to undertake basic medical care to our patients and free the senior personnel for teaching.

These appointments are renewable for up to one year. Accommodation will be provided on the A L E R T compound. Ordinarily, accommodation will consist of rent-free bachelor quarters, and the successful applicant will be expected to make his own arrangements for catering. If no bachelor quarters are available, residents will be accommodated in the students' hostel, and will be

charged 5 Ethiopian dollars per day for board. Apartments may be available for married couples at Eth. $100 per month. A salary of Eth. $500 per month will be paid.

Applications, giving *curriculum vitae* and the names and addresses of three referees, should be sent as soon as possible to Dr W. Felton Ross, Director of Training, A L E R T, P.O. Box 165, Addis Ababa, Ethiopia.

All-Africa Leprosy and Rehabilitation Training Centre, FELTON ROSS
P.O. Box 165,
Addis Ababa,
Ethiopia.