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Letters to the Editor

Dapsone Resistance in Patients with Treated Lepromatous Leprosy

Sir,

The excellent Editorial in your June number (Vol. 49, No. 2) by Dr Rees on "Combined Therapy in Principle and Practice for the Control of Dapsone Resistance" should be widely read and widely applied.

May I make one comment? Dr Rees rightly distinguishes between the two quite different aspects of the problem:

(1) To treat established proved dapsone resistance.

(2) To prevent the emergence of dapsone resistance by combined therapy.

The latter aspect is the subject of my comment. Dr Rees says "this involves every new lepromatous patient being treated at onset with dapsone on full dosage with at least one companion drug", and certainly everyone should agree and act on this statement. In my view, however, this is not enough. There are very many lepromatous patients who have been under treatment for many years—regrettably in many cases with unsupervised, and/or inadequate dosage of dapsone—and many of these must be "incubating" dapsone resistance. It is of note, particularly in certain West African countries, that dapsone resistance was until last year considered a minor problem. Now, however, cases are being recognized and the number of such cases will inevitably increase. From the public health point of view, the *already treated* lepromatous patient presents a more immediate danger of infection, and of the spread of primary dapsone resistance than the previously untreated patient. As Dr Pearson pointed out in Mexico the situation is analogous to that of an epidemic.

We must, therefore, give combined therapy, at least for a short period, to *all* cases of lepromatous leprosy; and in the very large group of previously treated patients who are attending our clinics, one such short regimen which combines safety and cost-effectiveness would be: Rifampicin 1500 mg in a single dose, with thiosemicarbazone 150 mg daily for 6 months, combined with dapsone 100 mg daily. This may be supplemented if local conditions make it feasible by an injection of acedapsone 225 mg every 3 months.

This regimen has the advantage of allowing us the possibility of using both Rifampicin and thiosemicarbazone or one of the thionamides again in combination with clofazimine if and when proven dapsone resistance emerges; but hopefully it should at least delay this occurrence.

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Reference

Pearson, J. M. H. The epidemiology and some implications of sulphone resistant leprosy. *Proceedings of the XI International Leprosy Congress.*