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# Letters to the Editor

## ADVERSE REACTIONS TO RIFAMPICIN AND DAPSONE

Sir,

The WHO short-term multiple drug regimen[1] was adopted in Guyana in December 1981 and during the subsequent 3 years the following adverse reactions to drugs have been observed:

*Rifampicin.* Two patients (one multibacillary and one paucibacillary) experienced a typical cutaneous syndrome in response to rifampicin as described by Aquinas.[2] The multibacillary patient was successfully desensitized but as the paucibacillary patient had previously received dapsone monotherapy and was inactive at the start of MDT desensitization was not considered worthwhile. This syndrome is quite different from any other drug reaction I have previously seen and exactly follows the pattern described by Aquinas. Proof of the causality of rifampicin was obtained by challenge with rifampicin alone.

*Dapsone.* Two paucibacillary patients developed adverse reactions to dapsone. The first developed an irritating, papular rash that cleared on withholding treatment. Challenge with rifampicin alone was uneventful but challenge with dapsone alone produced a florid rash and severe facial oedema. This patient completed treatment on supervised rifampicin and clofazimine only. A second paucibacillary patient developed a very insignificant, papular rash and as challenge with dapsone did not provoke any acute symptoms treatment was completed using a reduced dose of 50 mg daily. The rash healed leaving large, irregular, slate-grey blotches, rather than the typical, oval splashes of fixed drug eruption. However, as investigations did not reveal any alternative cause for the rash or the pigmentation I felt that the dapsone was probably responsible. This has recently been confirmed by the return of the patient with rash and facial oedema following self-treatment with sulphonamides for an incidental infection. Her leprosy remains inactive and the hyperpigmentation has completely cleared. Both responses to dapsone occurred within the first 6 weeks of treatment and may be considered hypersensitivity reactions.

The actual incidence of side-effects to rifampicin amounted to approximately 1 in 4500 doses given in the domiciliary programme. In the same period over a quarter of a million dapsone tablets were consumed without producing other than 1 mild and 1 moderately severe reaction. All 4 patients involved were women.

It is interesting to speculate why we should see 2 reactions to dapsone in 3 years compared with only 1 during the entire 11 years preceding MDT. Is this just a chance happening or are we becoming more alert to our patients' problems? One of the beneficial effects of MDT has been the fostering of improved staff/patient relationships. Could it be that patients who previously threw away their tablets in disgust and defaulted on encountering unpleasant side-effects are now returning to clinic in search of help? I look forward to hearing what is happening elsewhere.

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**References**

[1] Report of a WHO Study Group on Chemotherapy of Leprosy for Control Programmes. Oct. 1981; pp 24–5.

[2] Aquinas M, Allan WGL, Horsfall PAL, Jenkins PK, Hung-Yan W, Girling D, Tall R, Fox W. Adverse reactions to daily and intermittent rifampicin regimens for pulmonary tuberculosis in Hong Kong. *Br Med J*, 1972; **1:** 765–71.