Letters to the Editor

HOW INFECTIONOUS IS SECONDARY DAPSONE-RESISTANT LEPROSY?

Sir,

There is a growing view, supported especially by work in South India, that dapsone resistance does not pose such a serious threat to leprosy control as has been believed. One question which has to be answered unequivocally concerns the infectivity of secondary dapsone-resistant leprosy and, as far as I can ascertain, this has not been investigated. It is well known, of course, that skin smears from active lesions in a case of dapsone-resistant relapse show both BI and MI strongly positive, whereas those from clinically normal skin are generally negative, thus supporting a hypothesis that the total bacillary load is probably less than in an untreated lepromatous case. The frequency of positive nasal smears and nose blows, which would be more generally acceptable as an indicator of infectivity, has, however, not been recorded.

One study\(^1\) investigated the bacteriology of the nose in 62 lepromatous patients treated for varying periods with dapsone monotherapy. Nasal smears were examined from a total of 49 cases but in only one was the MI positive. Dapsone sensitivity was not investigated in this series.

I have myself reported infiltration and nodules of the palate and laryngeal involvement in patients with clinical evidence of secondary dapsone resistance.\(^2\) In these cases, however, nasal smears were not done.

In my opinion, there is a need for a well-planned study to determine the proportion of secondary dapsone-resistant cases which excrete viable *Mycobacterium leprae* from their nasal mucosa and thus constitute a potential source of transmission of disease. Such a study should be linked to an investigation of the probable index case in all patients with proven primary dapsone resistance.

H W WHEATE

34 Upland Road
Sutton
Surrey, SM2 5JE

References


TUBERCULOID LEPROSY AT THE SITE OF A DOG BITE

Sir,

Although it is well known that skin lesions of sarcoidosis sometimes appear in and around scars (‘scar sarcoidosis’), it is less well known that skin lesions of leprosy may originate in scars. Leprosy workers seem to have made little note of this interesting phenomenon, if reports in the literature are any criterion, and the only published photograph with which I am acquainted is given in Jopling & Harman\(^1\) in which a lesion of tuberculoid leprosy is shown involving 3 vaccination

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Figures 1 and 2

scars. These authors state: ‘leprosy lesions of all types tend to surround scars’. My interest in this subject has been aroused by the following case history:

A 45-year-old male reported at the Skin Clinic of the Western Railway Hospital, Bombay, with a hypopigmented skin lesion on the dorsum of his right forearm. The lesion measured 4 x 4 in., was flat in the centre and raised at the periphery, was anaesthetic and virtually hairless although situated in a hairy region of skin (Figures 1 and 2). No AFB were found in skin smears, and histology was diagnostic of tuberculoid leprosy. The patient stated that he had been bitten on that same forearm by a street dog 4 years ago, and the skin lesion appeared 6 months ago as a hypopigmented patch in the scar, subsequently enlarging to its present size. On examination, the scar could be seen in the central region of the lesion (Figure 2).

As leprosy has never been described in dogs, the question of Mycobacterium leprae having been introduced into the patient’s skin does not arise, but there is a distinct possibility that at some time in the future a case of leprosy resulting from animal bite may be reported. I have in mind the report of Lumpkin et al. on leprosy developing in 5 native-born Texans who handled wild armadillos, added to the fact that naturally-acquired leprosy has been found in the chimpanzee and the Mangabey monkey.

M P GARG

Western Railway Hospital
Maratha Mandir Road
Bombay 400 008
India

References