WHY CLASSIFY LEPROSY PATIENTS INTO PAUCIBACILLARY AND MULTIBACILLARY GROUPS?

Sir,

In technical report series 675(R) WHO recommend that all leprosy patients be divided into either paucibacillary or multibacillary types and that the former should have 6 months treatment only, the latter a minimum of 2 years, but continuing wherever possible until smears are negative. In paucibacillary cases, these may be diagnosed clinically or histopathologically '. . . with a bacteriological index of less than 2 according to Ridley scale at any site.'

It is already becoming apparent that mistakes are being made in the allocation of the patients into either paucibacillary or multibacillary groups for WHO regimens and in some countries this is aggravated by the fact that routine bacteriological examination of slit-skin smears is not properly carried out. I write to record my belief based on many years experience in India and Nigeria that there is in fact an inherent technical problem regarding the selection of body sites for routine skin smears. In addition to the selection of a site there are also problems in smear taking, staining and reading. Furthermore the peripheral nerves rather than the skin lesions may be far more important from a bacillary point of view. More and more cases with discrepancies in skin and nerve are being seen and for obvious reasons, nerves cannot be examined routinely for this purpose especially in the field. There is a need for clinical parameters which can be applied in the field for assessing the real bacteriological and immunological status of leprosy patients.

In tuberculosis treatment is standardized, no matter how many bacilli are revealed. Is there perhaps a case in leprosy for abandoning our attempts to divide patients into paucibacillary and multibacillary groups especially for chemotherapy and to give all of them a minimum of 2 years' treatment with 3 drugs?

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