THE CLASSIFICATION OF LEPROSY, A STATE OF CONFUSION

Sir,

In 1960, the 2nd WHO Expert Committee on Leprosy (TRS 189) agreed '. . . that radical changes in the classification from congress to congress should be avoided since such action would lead to utter confusion, neutralizing all efforts to arrive at the universal use of the same

terminology'. Ever since, discussions on the classifications of leprosy, aiming at a common terminology, have been carefully avoided. Now, some 27 years later, we still have utter confusion on which classification to use. Different programmes use different classifications, such as the Madrid (M), Indian (I), South American (A) or the Ridley–Jopling (R–J) classification, each having its own merits, as well as drawbacks. The latest revival of the old (Manila 1931 and Cairo 1938) 'administrative classification' (WHO TRS 71, 1953), dividing leprosy into 'open' (infectious) and 'closed' (non-infectious) forms, is the WHO (TRS 675, 1982) OMSLEP (3rd edition, 1987) recommended allocation of patients into multi- and paucibacillary (MB and PB) leprosy, implying a somewhat arbitrary division of cases according to their BI. Because of its simplicity, most of us are using this system, chiefly for the allocation of patients to be placed on MDT. Rather different from the R–J or M classifications, this MB or PB grouping (which by definition is a classification), tells us precious little about the immunological state of the patient. The BI can change this way or that way, the immune situation rarely does. For this reason, the systematic use of the lepromin (A or Ap) test, in the classification process was recommended by various authors; Noussitou (*Act Lepr*, **74,** 1–32, 1979) Jopling (*Lepr Rev* **52(3),** 273–77, 1981) Walter (PAHO Report, PNS: 56–61, 1984–5).

In practice, what decision do we now expect a programme director to take with regard to the use of a suitable classification and consequently the training of his staff? Should he choose between R–J, M, I or MB–PB, or use several systems? At this rate recording and reporting systems may have to change every 2 or 3 years and evaluation of programmes with different classifications may prove difficult or impossible. Why have different classifications of the same disease, 1 for research and the other for field work, the 1st assessing the merits of MDT in LI (LLs) and the other in MB forms of leprosy?

In order to minimize the present confusion, perhaps the forthcoming XIII International Leprosy Congress could make an attempt to devise a universal terminology for the classification of leprosy.

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