3 After the unfortunate experience of dapsone monotherapy and case reports of rifampicin resistant leprosy, rifampicin monotherapy appears to be unjustified even in PB leprosy patients. If resistance to rifampicin becomes ubiquitous as has happened with dapsone, we will lose the most potent antileprosy drug available to us today.

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References


FIELD DIAGNOSIS OF EARLY LEPROSY

Sir,

I would like to comment on Dr Smith’s paper (Lepr Rev, 1987; 58: 141–8) which describes the use of a questionnaire of 20 case histories. The diagnosis of leprosy is based on the presence of at least one of the three cardinal signs of anaesthesia, thickening of peripheral nerves at the sites of predilection and the finding of acid-fast bacilli. The 20 cases reported give no details of skin-smear results and diagnoses are made in the absence of any of the cardinal signs, e.g. case history 3 and 18. I note also that the location of the hypopigmented patches influences the diagnosis in two similar cases, when lesions are on the face (case 1) the response is ‘suspect’ while when on the buttocks (case 18) ‘affected’ is comparatively preferred.

I disagree with the diagnosis in case 1, since there is a history of contact with an infectious case ‘affected’ would be the possible correct diagnosis. I also question the diagnoses in cases 1, 8 and 12 where the sex of the child seems to influence the decision and I would disagree with the diagnosis in cases 13 and 19 which I find confusing.

However, despite my cautionary comments I do appreciate the attention that this paper gives to this much neglected area of leprosy.

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REPLY—FIELD DIAGNOSIS OF EARLY LEPROSY

Sir,

I have read Dr Kulkarni’s comments carefully and I welcome the opportunity to reply.

I wholeheartedly agree with Dr Kulkarni that this is indeed a much neglected area in leprosy and it has thus been with some trepidation that I have attempted to tackle the subject of the field diagnosis of early leprosy.

In defence of the ‘standard’ diagnoses used in the case histories I would point out that the majority of the 79 field workers who completed the questionnaire agreed with the standard
responses in 17 out of the 20 cases. However, the majority need not be correct and Dr Kulkarni’s reminder of the cardinal signs of leprosy is important. Yet he also from his comments seems willing to positively diagnose leprosy in the absence of any of the cardinal signs (Case I). This raises the whole issue of the place of the cardinal signs in the diagnosis of early leprosy. It is often our least experienced leprosy staff who are left with these difficult decisions on diagnosis of early disease—attempting to get the right balance between missing true cases and overdiagnosis and overtreatment. This has also implications for the validity of regional comparisons of the prevalence of leprosy. Dr Kulkarni makes an interesting point about the factors which influence the decision, e.g. sex of the subject, history of contact, and the site of the lesion. This opens up areas for further operational research. I would be interested in hearing from anyone else who has used the 20 case histories.

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ARE BACTERIAL COUNTS ON SLIT-SKIN SMEARS IN LEPROSY AFFECTED BY PREPARING SLIDES UNDER FIELD CONDITIONS?

Sir,

Several years ago we carried out simple trials on more than 300 patients/slides over a 6-month period. It was our finding that no difference was found if the slides were dried in the sunlight or shade if drying time was never longer than 5 minutes. We did find a difference when the slides were not stored in a lightproof container after fixation and up to the staining period. The main difference that we encountered was the difference in the quality of smear collection between skin-smear technicians who receive longer more intensive training and work continually with the same work and that of paramedicals who received what we consider very limited training experience in collecting smears. We later also checked the readability of slides after staining and stored in light and non-lightproof containers with oil left on the slide and slides washed. There appeared to be no significant difference between the latter but the results were marked if they had not been stored in airtight lightproof containers. The collection of the smear is what we find needs continual supervision and monitoring.

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