nerve was found to be thickened and tender. Haematoxylin and eosin stained sections revealed a granuloma formed by a large number of lymphocytes, epithelioid cells and giant cells. The granuloma was well formed and located just below the epidermis. Some of the cells were seen infiltrating the epidermis (exocytosis) (Figure 2). The nerve in the granuloma could not be identified and no acid-fast bacilli could be demonstrated in tissue sections and slit-skin smears. Lepromin (Mitsuda) was strongly positive. The diagnosis of tuberculoid tuberculoid (TT) was thus confirmed and the patient has been prescribed multidrug therapy comprising of 600 mg rifampicin once a month and 100 mg of diaminodiphenyl sulphone daily.

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References

LEPROSY SCORE CHART TO ASSIST CLASSIFICATION

Sir,

In Papua New Guinea (PNG) we have for some years used a clinical score sheet to assist in the diagnosis of tuberculosis in children. The score sheet is easy to fill in and well used by a wide range of health workers, from medical officers in hospitals to rural health workers in health centres.
throughout the country. Doubts have been raised\textsuperscript{2,3} about the quality of leprosy smears and leprosy microscopy services in many countries and we have also experienced similar difficulties in our own Multiple Drug Therapy (MDT) programme in PNG.\textsuperscript{4} Bearing in mind the above, we have developed a Leprosy Score Chart to assist in the classification of cases in our MDT programme, and to help minimize errors in classification. We have developed the following Leprosy Score Chart based on our TB score chart:

<table>
<thead>
<tr>
<th>Clinical finding</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patches</td>
<td>0–5</td>
<td>6–20</td>
<td>20+</td>
<td></td>
</tr>
<tr>
<td>Sensation</td>
<td>Absent</td>
<td>Reduced</td>
<td>Normal</td>
<td></td>
</tr>
<tr>
<td>Edge of lesions</td>
<td>Obvious</td>
<td>Satellites</td>
<td>Unclear</td>
<td></td>
</tr>
<tr>
<td>Loss of pigment</td>
<td>Yes</td>
<td>Some</td>
<td>Very little</td>
<td></td>
</tr>
<tr>
<td>Surface raised</td>
<td>Edge only</td>
<td>Centre</td>
<td>Nodules</td>
<td></td>
</tr>
<tr>
<td>Enlarged nerves</td>
<td>Less than 2</td>
<td>2 or more</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Muscle tests failed</td>
<td>Less than 2</td>
<td>2 or more</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central healing</td>
<td>Yes</td>
<td>None</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Patients with a score of 12 or more are classified as multibacillary (MB). All others are classified as paucibacillary (PB) unless smear result suggests MB, i.e. BI 2 or more. BILATERAL SYM-METRICAL EAR LOBE INFILTRATION IS AUTOMATICALLY MB.

We would appreciate comments from readers to assist us in further development of this concept. We are certain that there must be some clinical criteria available in a simple format to assist all health workers in classification of patients for MDT. We feel that we cannot afford to rely totally on laboratory services, which are often inaccessible or unreliable in developing countries.

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References