REPLY: LEPROSY IN CHILDREN

Sir,

Leprosy in children is now a well-established entity.[1–3] It is characterized by well-defined hypopigmented macule(s). Their border may either be regular or serrated. Usually they are few in number and erythema and loss of hair may also be present. The sensations in the macules are invariably impaired or lost. The nerves feeding or supplying the lesions may be enlarged and tender. The macules are largely disposed over body areas susceptable to trauma or injury. Occasionally, plaque(s) may also be encountered. The morphology of the lesions usually corresponds to either indeterminate or tuberculoid (TT) or borderline–tuberculoid (BT).[4] Occasionally, however, borderline–borderline (BB), borderline–lepromatous (BL) or lepromatous (LL) may be seen, indicating clearly that the spectrum in the 0–14 year age group is incomplete. The reactions and deformities are infrequent.[3] Because of the relative innocuous nature of the clinical manifestation, leprosy in children is seen rarely. During the last decade (1981–89) 127 children had leprosy amongst 2513 new leprosy patients attending an urban leprosy centre.

Furthermore, the parameters, namely bacterial index and microscopic pathology are largely unhelpful in this group. Nevertheless, it is imperative that they are performed in each case.[5–7] The early features of leprosy in children have been reported recently.[7–9] It is to be appreciated that the contrasting clinical features observed certainly warrant further attention. In a recent work[10] an endeavour has been made to unfold this aspect by instituting the estimation of total T-lymphocytes, their subsets CD_4 (inducer) and CD_8 (cytotoxic) and their ratio in the peripheral blood, with equivocal results. Whereas *in vivo* lepromin (Mitsuda) and epicutaneous sensitization with dinitrochlorobenzene (DNCB) were significantly poor in mid-borderline (BB) leprosy. B-lymphocytes serum immunoglobulin and C_3 pivotal complement component were found to be normal in all leprosy groups.

The preceding account, therefore, comprehensively shows that the diagnosis of leprosy in children is not at all in doubt. This has been further confirmed by the favourable response to chemotherapy.[11] Therefore the conclusion drawn that the diagnosis should be clinical is well placed.

It is hard to subscribe to the contention that separate operational criteria for diagnosis from those used for leprosy research should be adopted because it may be difficult to compare the cumulative data of different studies. Hence the author has proposed a seven-group classification, which could be utilized for institutional and field work.[12,13]

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