COMMENT: A LOOK AT WORLD LEPROSY

Sir,

Recommending multibacillary (MB) drug regimes to erstwhile MB cases, who for decades have been smear negative following prolonged periods of dapsone monotherapy is a debatable issue

despite consensus among many leprologists and widespread compliance. WHO recommendations have been brought to light in your special article (*Lepr Rev* 1991; **62:** 72–86). Though these were made under 'very special circumstances' and were directed 'primarily towards leprosy control' it does not clarify many issues. What of the individual who has had no signs of activity whatsoever, no clinical or bacteriological evidence of leprosy for at least 10 years and has further received many years of dapsone monotherapy prior to achieving smear negativity? Am I right in understanding that in such an unsuspecting individual instead of stopping his therapy, we administer two other drugs for 24 months? While I concede that there may be epidemiological reasons for this, where is the definitive clinical indication? Also does lepromin negativity by itself warrant therapy? Clofazimine therapy while relatively well tolerated may still occasionally result in abdominal emergencies. Skin discolouration is also unacceptable to many and this in itself has become a stigma of late. Rifampicin too has its well known hepatic and renal side-effects.

There being no clear clinical indication to commence fresh therapy in such situations I would prefer to stop monotherapy and have regular yearly reviews of these patients for life. I must concede that this is applicable only to 'special settings' like ours where most such treated MB cases live in a colony, a stone's throw from our base hospital and who are not likely to abscond. If it is 'persisters' that one is concerned about a compromise could still be made by choosing the WHO's PB MDT regimen to eradicate them, thus avoiding the addition of a third drug. At least under such 'special circumstances', clinicians must have the freedom to assess individual cases on their own merit and choose an appropriate line of management. I personally feel that directives from governmental and other authorities should not infringe on the rights of individual clinicians to pursue a rational line of management, at least in special situations. Also the ethical question of giving new drugs to apparently healthy individuals while at the same time avoiding negligence remains to be answered. What would be your (or the author's) advice for situations like this?

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