ethionamide should be replaced by other drug(s) that were unknown when the above studies were undertaken.

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COMMENT: LEPROSY DEFORMITIES: EXPERIENCE IN MOLAI, NIGERIA

Sir,

I read with interest the paper by B B Iyere, 'Leprosy deformities: experience in Molai Leprosy Hospital, Maiduguri, Borno State, Nigeria', (Lepr Rev, 1990; 61: 171–9).

Lagophthalmos was tested in this article by asking the patient to close his/her eyes as tightly as possible . . . if there was a lid gap, it was recorded as lagophthalmos. This procedure however will lead to an underestimation of lagophthalmos. 'Generally the delicate palpebral fibres fail before the stronger orbital ones, thus a patient may sleep with the cornea exposed, yet can close the lids by voluntary effort'. In milder degrees the patient may be able to close the eyes by voluntary effort, while they may remain open in sleep, but in the more pronounced degrees even forcible squeezing becomes ineffective and the eyes remain permanently unclosed.

It is therefore recommended to test for lagophthalmos by asking the patient to close his/her eyes mildly, as in sleep and then to observe and measure the lid gap in millimetres.

Any gap of ≥1 mm is considered to be lagophthalmos. In the case of a gap in mild closure of ≥5 mm or if the lower part of the cornea is exposed during mild closure eyelid surgery is recommended for better closure and protection of the eye.

To test for lid weakness, if there is no gap on mild closure, the patient can be asked to close his/her eyes as tightly as possible, while the examiner tries to pull the eyelids gently apart.

From the results mentioned in the article: eyelid weakness was found in 2.7% of the males and 17.6% of the females, whereas the lagophthalmos found is more or less alike, 2.2 and 3.1% respectively, one may wonder if the women for cultural or physical reasons may have given less resistance towards forced opening of the eyelids than the men. In my experience eyelid weakness and lagophthalmos occur alike in both sexes.

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References


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
Letters to the Editor

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. 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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REPLY: RECOMMENDING DRUG REGIMENS TO SMEAR NEGATIVE MB CASES AFTER PROLONGED DAPSONE MONOTHERAPY

Sir,

The question of how to deal with dapsone-treated smear-negative multibacillary patients was discussed in the WHO Expert Committee on Leprosy. Sixth Report (WHO Technical Report Series No. 768, 1988) which made the recommendation that, where resources permit, such patients should be given MDT for two years. It is this recommendation that is referred to in my paper. The reason for giving MDT is to prevent relapse which occurs at the rate of about 2% of patients per year. While the recommendation of the Expert Committee is generally for leprosy control programmes with the proviso ‘where resources permit’, in individual instances judgements may have to be made on the basis of the specific local situation. In a wider context, it is pertinent to point out that one of the factors making leprosy control successful through MDT possible is the application of standard treatment regimens and procedures rather than individualized treatment approaches.

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