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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