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presumably in a pessimistic mood about understanding leprosy, while he has distinctly expressed his optimism about the disappearance of the disease. Indeed since he said this in 1994, the situation has improved (and not deteriorated) with special strategies spearheaded by WHO to unearth new cases and implement short course chemotherapy. If we had any qualms we might never have got started.

As regards the interesting concept of making a disease disappear by not looking at it is perhaps applicable to highly inaccessible pockets. Inspite of heavy odds people have started looking at them after all. Even if one looks at all of them all the time, I am afraid leprosy will not reveal its true incidence rates! This is the reason why the problem of raising funds, as rightly pointed out by Dr Fine assumes tremendous significance as it poses a threat for future research in leprosy and may lead to less people looking at this disease. This will indeed be a tragedy.

Even laymen in India have felt the tangible reduction in the disease burden in both rural and urban communities, though by the application of strict standards of incidence criteria, leprosy elimination still poses considerable challenges. I believe that eliminating most or even some of the problems should be most welcome under the current constraints. While understanding of basic aspects of transmission (as proposed by Dr Cairns Smith) as well as further refinement of operational and reporting strategies (as Dr Fine would have it) will not only lead to elimination and perhaps even to a ‘world without leprosy’, but also to total understanding of the disease by all of us concerned.

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References

1 Smith WCS. We need to know what is happening to the incidence of leprosy. Lepr Rev, 1997; 68: 195–200.

SINGLE-DOSE RIFAMPICIN, OFLAXICIN AND MINOCYCLINE (ROM) THERAPY FOR SINGLE LEPROSY LESIONS

Editor,

A single dose of drugs for the large number of single-lesion cases detected annually in endemic countries would help in keeping the elimination of leprosy on schedule. A multicentre trial involving 1381 patients followed-up for 18 months after the dose was published in the Indian Journal of Leprosy and presented at the recently concluding XXth Biennial Conference of the Indian Association of Leprologists. Some of the participating centres presented the findings in their patients included in the trial. Comments on the trial and possible indications for single-dose therapy are given below.

The study did not consider: 1, site; 2, size; and 3, classification of the lesions as important factors when including the patients. The significance of these is considered with illustrations where available.

Site. In the clinical transparencies presented by one centre, there were at least two showing macular lesions on the face. It is well known that it is difficult to elicit sensory loss on face lesions on account of the rich nerve supply. Therefore diagnosis of macular lesions on the face poses a problem.

Certain sites, e.g. face, hands and feet are considered as strategic since regional nerve trunks, ulnar and lateral popliteal and when palmar and plantar lesions are present (not uncommon in some parts of South India) median and posterior tibial nerves are involved. Even though they may not be enlarged at the time of examination often Mycobacterium leprae lurk in these nerves. During therapy
or after as a part of reversal reaction acute painful neuritis may be encountered in these nerves. In the rifampicin, oflaxacin and minocycline (ROM) trial neuritis was observed in 3 cases. It would be interesting to have the incidence of neuritis according to site of lesions. The significance would be great when ROM is administered as routine and the patients are not seen afterwards resulting in disabilities.

Size. The larger the size, the greater the number of nerves involved in the dermis. Consequently the number of bacilli would also be more. Such lesions are also prone to reversal reaction; they would provide instances of treatment failure due to inadequate treatment.

This is illustrated in Figure 1, where a large BT lesion covers most of the race; the raised edge can be seen on both sides of the forehead. Powdery scales are the embers of a reversal reaction during paucibacillary multidrug therapy (PB-MDT). Steroid therapy stemmed the damage in the facial and trigeminal nerves, which could have resulted in lagophalmos and corneal anaesthesia followed by the dire consequence of exposure keratitis. Such a case is not suitable for single-dose ROM without followup.

Classification. In all the centres participating in the trial enough expertise was available for bacteriological examination. Only negative cases were included. Even so the clinical transparencies presented by two centres differed in clinical characteristics. One of the centres presented raised lesions with prominently thickened nerves, whereas another presented macular lesions. One of the lesions from the former, presented a lesion with rounded edges which could have been classified as midborderline leprosy.

Figure 2 shows a rounded lesion on the cheek with abrupt inner and sloping outer edges with a normal centre. The erythema denotes activity. A skin smear from the outer edge was positive for acid-fast bacilli (AFB) with a BI of 2. This was the only lesion observed.
Figure 3 is of a single lesion in one year after PB–MDT. An extension of the lesion can be identified where the previous edge can be seen, and beyond it another edge which seems to be in the process of advancing. The edge here and proximally is sloping. The surface is rugged. Sensations were impaired. A femoral cutaneous nerve can be seen coursing under the hypopigmented area of the lesion—BI 2 + Classification BL (histological) following treatment failure.

Figure 4 depicts a large hypopigmented lesion, flat, with ill-defined margins. Sensations were diminished—BI 1 + Classification (macular) BL.

These cases are presented to emphasize that all single lesions should not be considered as paucibacillary. It is also useful to remember that relapsed lesions of lepromatous or BL leprosy, particularly those flowing dapsone monotherapy, may present as single papules or macules or plaques. Skin smears would be strongly positive.

While the outcome in the trial as regards complications has been similar to that of PB–MDT, it should be noted that in PB–MDT the patient is under medical care for 6 months and under surveillance for 2 years. Patients after a single dose of ROM would be unobserved.

Indications for ROM single-dose therapy: Firm instructions on the use of ROM should be issued, perhaps on the lines given below:
A single dose may not be harmful in single nonleprosy lesions diagnosed as leprosy in the field. Lesions with equivocal sensory loss. The usual advice is to keep the patients under surveillance till either signs of leprosy develop or the lesion disappears. ROM single-dose therapy might abort the lesion. Early single macular lesions (Indeterminate) which are observed to heal in 11% of cases (Lara & Nolasco) would benefit from the treatment. Tuberculoid major lesions which were found to heal, scar or never downgrade in a study of the natural evolution of leprosy (Ramanujam) are likely to respond early to treatment. The above listed types of single lesions would cover nearly 95% of single lesions in the field. Five per cent of cases would call for care in classification and management to minimise disabilities and treatment failure.
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References


2 Lara CB, Bolasco JO. Self healing or abortive and residual forms of childhood leprosy and their probable significance. *Int J Lep.*, 1956; 24: 245–263.


UVEITIS IN LEPROSY PATIENTS WHO GOT INACTIVE CONDITION IN PRE-WHO/MDT ERA

Sir,

Among the various ocular diseases caused by leprosy, complications of the uveal tissue are considered to be the leading courses of blindness.\(^1\) Apart from uveitis relating to active leprosy, the occurrence of uveal inflammation long after the disease becomes inactive as defined by standard criteria is also well known.\(^2\) In Japan leprosy has almost been eradicated, but doctors frequently see the inflammatory conditions in anterior chambers of leprosy patients even though their disease has long been quiescent.\(^3\) Our study examined the cases of on-going uveitis in patients whose leprosy had been quiescent for more than 10 years.