

COMMENTARY

Is it safe to shorten multidrug therapy for lepromatous (LL and BL) leprosy to 12 months?

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In some ways, Dr Ji's Editorial is written 2–3 years too soon, as a 7–10 year follow-up is desirable to assess relapse rates after all save very short or weak regimens.^{1,2} The WHO ofloxacin controlled clinical trial, which includes the 12 month WHO MB regimen compared with the standard 24 months, only commenced intake of patients in 1992. Moreover, the proportion of patients in each group having a relatively low bacterial index (BI) of 2·0–3·0 has not yet been reported.

Changes in the definition of MB leprosy, first to include all smear-positives, then all with more than five skin lesions, were made for field convenience only, because of the poor standard of skin smears. It was motivated by the fear that borderline patients, misdiagnosed as PB, might relapse if wrongly given PB MDT; yet only a relatively small proportion of such relapse patients are likely to be significantly infectious. The resulting widening of the original MB group has led to a large increase in MB numbers, both proportionately and absolutely, with a corresponding increase in work load, a possible diluting of 'genuine' MB relapse figures and a cry to shorten the duration of MB treatment, which is certainly unnecessarily long for the newly included types of patient.

Transmission of leprosy is largely, if not almost entirely, from active untreated or relapsed LL and BL patients. Although field studies in general have reported very low rates of relapse, relapses reported in carefully studied, highly bacilliferous LL and BL patients have sometimes been unacceptably high after 2 years of MDT. The Institut Marchoux² has reported that seven out of 35 (20%) of such patients, or seven out of 18 (39%) of patients with an initial BI of 4·0 or greater, subsequently relapsed, five relapses occurring more than 60 months after stopping MDT; most relapses have been confirmed by mouse footpad inoculation of these strains of *Mycobacterium leprae*. Ji also quotes a personal communication from Girdhar that relapse rates are significantly higher among MB patients with an initial BI \geq 4·0. Very recently, Ganesapillai (personal communication) has also reported that two of 35 LL and BL patients treated for 2 years with WHO MDT in a controlled clinical trial had relapsed after less than 5 years of follow-up. It is to be hoped that both these latter two workers will present full reports in due course.

These new data, which are beginning to be reported, support the view that more detailed results, obtained over a longer follow-up period, are required before one can safely judge whether it is safe to reduce the duration of MB MDT given to LL and BL patients whose initial BIs are greater than 4·0. It is perhaps ironic that fear of relapse in borderline leprosy has eventually led to medico-political pressure to reduce the duration of treatment in advanced lepromatous leprosy. In addition, relapses–infectious relapses–may well become much

harder to detect in LL and BL patients, once leprosy services become fully integrated after the year 2000, and therefore could slow down the eventual eradication of leprosy. The WHO Seventh Expert Committee on Leprosy³ was prepared to complicate MDT by introducing a third regimen (the 1 day MDT for single lesion leprosy); it is strange that it was not prepared to wait another 4 years for the results of the WHO ofloxacin trial before shortening the duration of treatment for highly bacilliferous LL and BL patients.

References

- ¹ Marchoux Chemotherapy Study Group. Relapses in multibacillary leprosy patients after stopping treatment with rifampicin-containing combined regimens. *Int J Lepr*, 1992; **60**: 525–535.
- ² Jamet PJB, Marchoux Chemotherapy Study Group. Relapse after long-term follow-up of multibacillary patients treated by WHO multidrug regimen. *Int J Lepr*, 1995; **63**: 195–201.
- ³ WHO Expert Committee on Leprosy, Seventh Report. *WHO Technical Report Series No. 874*. World Health Organization, Geneva, 1998.