CORRESPONDENCE

Kalaupapa, Hawaii
July 11, 1947

To the Acting Editor:

The reports of the Pan-American Conference are extremely interesting and should furnish a good basis for consideration of the primary problems of classification and therapy at the coming Havana Congress. There the presence of workers from other parts of the world will give the needed additional touches to the "provincialism" of those who have seen leprosy only on or near the American continent.

Partly as an expression of personal opinion, partly because some of the statements made appear to disagree with our experience in Hawaii, I am offering some comments on a number of items and on the editorial in the same issue of the JOURNAL (vol. 15, no. 1).

P. 88. Editorial. Now that drugs are at last available which are of real therapeutic value in lepromatous leprosy, I see no slightest excuse for subjecting lepromatous patients to further suffering as "controls" with the useless chaulmoogra preparations. Long before the sulfones were available, I felt it would be a great forward step if the time, money, and effort being wasted on chaulmoogra oil could be devoted to research in the effort to find an active drug. Now such drugs are here; and it is shocking to find workers still clinging to the outdated oil! Certainly we need a large scale study program. Compare the different sulfones; compare early and late cases; compare lepromatous and tuberculoid cases; make thorough studies of dosage and toxicity; by all means try new drugs, especially new sulfones; but let no more work be wasted on drugs which, if they have any value at all in lepromatous leprosy (and that is questionable) are so far outshadowed by the sulfones that they should be forever forgotten.

Perhaps there is a little to be said for chaulmoogra in tuberculoid cases. Reports of sulfone therapy in such cases are conspicuously lacking. Our own series is as yet too small to be of value. So if chaulmoogra *must* be used, let it be here; but do it in a place where tuberculoid cases are common. And use bland oils and other liquids for the plancha treatment, as well as chaulmoogra. (But if I were the patient, I would choose the sulfones.) Of course, we all know that the tendency of tuberculoid cases is toward recovery without treatment; I have often wondered whether that fact does not account for much of the enthusiasm of the Philippine workers for chaulmoogra.

P. 89, item 3. Where on this globe can you find even one "interested, unbiased, and experienced investigator"? Have not most of us found that experience leaves us with a definite bias? My experience with chaulmoogra led me to discard it; my experience with sulfones leads me to want to continue and to expand it, and to hope for still better drugs.

Apart from this, the plan is excellent. I agree: "There must be no turning back."

P. 100. Classification. The basic ideas, that leprosy is a disease of the whole patient and not of his skin and nerves, and that there are two fundamental types of leprosy, now called lepromatous and tuberculoid, seem to be correct. We have been convinced of this for some time in Hawaii (see Arnold, H. L., Jr., and Tilden, I. L.: The Classification and Nomenclature of Leprosy, with Suggestions for the Simplification of Both. Ann. Int. Med. 23: 65 (July) 1945; and Arnold, H. L., Jr.: Differentiation of Lepromatous from "Neural" Leprosy. Arch. Dermat. & Syph. 52: 534 (Nov.-Dec.) 1945). But to speak of "uncharacteristic" leprosy seems wrong to me. If a patient has signs which are sufficiently characteristic to justify a diagnosis of leprosy, then the mere fact that clinically or pathologically they cannot be classed as lepromatous or tuberculoid does not make them any the less characteristically leprous.

The word is "undetermined." My conception is that a patient of this group (not "type") will follow one of four courses, if untreated by sulfones:

(1) It is conceivable that he will remain permanently in the situation first observed. Has any one seen such a case?

(2) He will recover without further progress of the disease. Probably many do so without ever being diagnosed.

(3) He will become definitely lepromatous.

(4) He will become definitely tuberculoid.

In other words, these are the patients whom we cannot for the moment classify because our diagnostic skill and methods are not good enough; but time will usually bring the answer.

P. 101. Definition of Types. Lepromatous. "Severe and intractable cases . . ." Not always severe, by any means. "Intractable" was true in the chaulmoogra days, but not now.

P. 102. Tuberculoid Type. "As a rule, the bacteriological examination is negative, but, when positive, the bacilli are generally very scarce." That depends on the way it is done. The Wade scraped incision is frequently, perhaps usually, negative. But if one examines a biopsy specimen stained by Fite's method the per-

centage of positives rises rapidly. (Such an examination is a prerequisite for parole in this institution.)

Moreover, the number of bacilli tends to be greatly increased during tuberculoid reaction, and may be as great as in some lepromatous lesions.

"The only thing which identifies these cases (e.g., reacting tuberculoids) with the non-reactive tuberculoid type is the histologic appearance." I disagree—if we are speaking of the same thing. With experience they may often, although not always, be distinguished clinically. And histologically they may so closely resemble lepromatous lesions that they cannot be distinguished; but in time they revert to the more usual tuberculoid histology.

P. 102. Description of Lesions. Here the committee attempted much too much. No matter how great a variety of lesions is described, some one will produce another.

Lepromatous macules. Our experience is that in dark skins these are apt to be *hypo*-pigmented, and at times difficult to distinguish from early tuberculoid lesions.

Lepromatous "tubercles" and "nodules." The distinction between intra-dermal "tubercles" and subcutaneous "nodules" is new to me. As a matter of fact, I have rarely seen (or felt) a 'palpable subcutaneous lesion" before the days of sulfone treatments, apart from frank nerve nodulations. Now we sometimes see transitory ones (perhaps associated with non-palpable nerves?) in the course of therapeutic reactions.

P. 104. Tuberculoid type. Extensive lesions with grossly smooth, shining, usually hyperemic surfaces are almost as common here as are ring lesions.

Neurological symptoms. The committee refer to "nerve biopsy." Do they slice functioning nerves, thereby interfering with their function, perhaps permanently? Oh what do they mean by the term?

P. 106. Histology. "We recommend that the biopsy should always be done surgically." How else could it be done? Presumably they mean knife or scissor excision of a piece of skin rather than skin biospy. The point should be made clear.

"A lepromatous lesion is a specific granuloma characterized by vacuolated cells of Virchow." Not always; Virchow cells may be scarce or absent; and when present they are not diagnostic of leprosy. The granuloma *is* composed principally of cells derived from the reticulo-endothelial system. (See Tilden, I. L.: Lepromatous

Leprosy: A Reticuloendothelial Disease. Amer. J. Clin. Path. 15: 165 (May) 1945.)

"A tuberculoid granuloma accompanied by exudative phenomena of hyperemia and edema which changes its characteristic appearance (vacuolization by edema)." This verbless and thereby meaningless sentence has probably been discovered by now and corrected for future editions.

"The histological examination is of absolute value in the diagnosis of the lepromatous type." As noted above, a reacting tuberculoid lesion may be indistinguishable.

P. 114. Subcommittee on therapeutics. As noted above, I heartily disapprove continued use of chaulmoogra oil in lepromatous patients. Otherwise, the report is good.

And in closing: Sulfones are *not* "sulfa drugs." That term should be reserved for sulfonamides.

The term "tuberculoid" is unfortunate. To the patient it conveys the idea of tuberculosis, and may be distressing. It is to be hoped that some one will produce a better name before this is irreparably embodied in the official classifications.

Very truly yours,

NORMAN R. SLOAN, M.D.
Medical Director, Kalaupapa Settlement