CORRESPONDENCE

This department is provided for the publication of informal communications and for discussion of controversial matters.

The Acting Editor has received the following letter from Bernard Moiser, O.B.E., M.R.C.S., D.H.P., late civil servant, Medical, P. O. Kinangop, Kenya.

To the Acting Editor:

Referring to the JOURNAL, Volume 15, Number 1, page 114: Dr. Suarez of Bolivia calls attention to the special topography of his country which renders it suitable for epidemiological inquiries as to the effect of altitude and climate on the incidence of leprosy. He states that there is no leprosy in the "Andean altiplane," moderate incidence in the middle level and high incidence at sea level. Other members at the Second Pan-American Conference suggest that it would be instructive to investigate the alleged absence of leprosy in the Bolivian "altiplane," as well as the repeated statements that the disease does not exist in Chile.

This is especially interesting to me since I have been working for several years on cockroaches as possible transmitters of the disease. My belief, as a result of thirty-four years of experience, is that leprosy is not directly infectious or contagious from man to man, but that passage through the cockroach is necessary for a development stage to take place, in order to render the bacilli infective to man (on similar lines to the development of the malaria parasite in the mosquito).

BERNARD MOISER

Honolulu 53, Hawaii
October 24, 1947

To the Editor:

Dr. J. N. Rodriguez should be complimented upon the clarity with which he demonstrates the essential identity of nearly all the proposed classifications of leprosy (Int. J. Leprosy 15, (1947) 274). I have long felt that there have never been more than one classification, notwithstanding the remarkable variety of the terminology with which that classification has been clothed.

On page 291, however, he says "Starting with the Danielssen and Boeck Classification in 1848 to the 1931 Manila one, the basis was morphological, that is, the distinction between the two types was based on whether the skin or the nerves were chiefly involved." This serious criticism is perfectly justified in the case of

Danielssen and Boeck, and in the case of the Manila Conference; but its application by inference to Dr. G. Armauer Hansen is altogether unfair and incorrect.

Hansen divided leprosy into two forms, which as he said were "pretty sharply distinguishable on clinical grounds": tubercular ("tubercle" being the word of the day for what we would now call a "nodule") and maculoanesthetic. He stated in unmistakeably clear language that the localization of lesions (i. e., in skin or in nerves) was of little help in distinguishing them from one another, since *both* skin and nerves were involved in *both* types. He warned against the purely neural category created by Danielssen and Boeck, as being a potent source of confusion, since, as he said, nerve involvement occurred at some stage in both types and might at any one time be the sole evidence of involvement in either type. He knew that visceral involvement was limited to the lepromatous type, and that tuberculosis and amyloid disease frequently complicated it whereas they rarely occurred in tuberculoid cases. And he recognized that the "macule," whether true macule or plaque, of the maculoanesthetic form of leprosy, was regularly anesthetic: hence the term maculoanesthetic. Indeed, though the South American dermatologists have put this classification of leprosy on a sound biologic and histologic basis, it is difficult to see that they have altered it in any fundamental respect. By all rights of priority, it should be known to all as the Hansen Classification of leprosy.

— Harry L. Arnold, Jr., M.D.