REMARKS ON "LUCIO" AND "LAZARINE" LEPROSY

TO THE EDITOR:

With reference to the article of Doctors Latapí and Chavez on the "Lucio" or "spotted" (*"manchada"*) form of leprosy, which was presented by them at the Havana Congress and was published in translation in the last issue of THE JOURNAL [16 (1948) 421-430], I may say that when visiting Mexico after the Congress I was shown cases of that condition and some sections from their lesions. Perhaps better called the "Lucio phenomenon," so far as I could make out it is a particular variety of lepra reaction in lepromatous cases with diffuse lesions. It is not any separate or new type of the disease, in my opinion, and Professor Latapí was of the same view.

After my visit to Mexico I made a point of looking for cases with similar manifestations when visiting Argentina, Brazil, Nigeria and other places, but I was told by the workers there that they themselves had not observed similar symptoms. With the limited knowledge of these countries which I have, it is difficult for me to say whether or not cases of the Lucio phenomenon are seen in them. Here in India we do have diffused lepromatous lesions, but I do not remember having ever seen in those cases anything like the phenomenon referred to. On the

other hand, I am not in position to say it is never seen here; and I shall be on the lookout for it in the future.

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TO THE EDITOR:

After the Havana Congress, when it was expected that I would go to visit Mexico before returning to Argentina, I was asked to give you my impression of the so-called "Lucio leprosy" which is supposed to be peculiar to that region. Last minute developments prevented my visiting that republic. However, it happened that when visiting the U. S. National Leprosarium at Carville, Louisiana, I had an opportunity to see and examine a case of that condition in a young man, about 25 years of age, who was of Central American origin.

Judging from this case, "Lucio leprosy" would seem to be a special form of lepromatous reaction in a diffuse lepromatosis; that is to say with little or no tendency to localize in nodules. In our country we occasionally see a condition which we classify as severe reaction, similar in many respects to the Lucio form but without the manifestations of purpuric and necrosing capillaritis. Typical Lucio leprosy has never been seen here. In my opinion it is a severe reaction in a diffuse lepromatous case, *plus* the purpuric and necrosing spots (*manchas*).

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TO THE EDITOR:

Some interest has been shown of late in certain unusual manifestations of leprosy, which were discussed last year at both the International Leprosy Congress in Havana and the Congresses on Tropical Medicine and Malaria in Washington—on the latter occasion under the heading of "lazarine leprosy." Personally I think it is a mistake to make new *types* of leprosy, either "lazarine" or "diffuse" as they are calling now the Lucio form.

I should say rather that these are unusual symptoms or phenomena in the course of lepromatous or tuberculoid leprosy, and I should like to call them the "Lucio phenomenon" or the "lazarine phenomenon," meaning the presence of bullae with necrotic lesions. That some unusual cases present these bullae

with following necrosis is unquestionable, but I hate to complicate matters by making *new forms* of leprosy out of that fact. Obermayer's articles on "diffuse leprosy" illustrate the sort of confusion that I dread. As if diffuse leprosy were not lepromatous leprosy with a peculiar reactivity on the part of the patient. . . .

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TO THE EDITOR:

With reference to the statement which appeared in the discussion of the Washington Congresses paper of Drs. Pardo Castelló and Piñeyro, that the "Lucio phenomenon" is by no means unusual in South Africa, there has been a misunderstanding somewhere.

We do see occasional cases of the tuberculoid type which have acute reactions with a slight tendency to very superficial ulceration, but I personally have known only three of them. The scar left after such ulceration is never completely devoid of pigment. However, if bulla formation is one of the essential stages of "lazarine leprosy," then we can state with certainty that this condition is absolutely unknown in South Africa.

Extremely common, on the other hand, are the tropic bullae which occur principally on the hands and rarely on the feet of neural cases. These blebs, usually about ½ inch in diameter, start with clear fluid which may turn milky or become hemorrhagic. When the blister breaks the base shows ulceration with red healthy-looking granulation. These ulcers heal slowly, and the resultant scars are dead white and hard to the touch.

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TO THE EDITOR:

Regarding "lazarine leprosy," about which Dr. Davison has written separately, I, myself, can recollect having seen only two cases of multiple ulceration associated with neural-type leprosy. They were presumably tuberculoid cases. There is no history of bullae prior to the ulceration. One of them is still detained here and shows, histologically, lepromatous change on a background of much circumscribed scarring.

In South Africa, bullae on the hands are common in neural-type cases with well-established trophic disturbances. They

occur less frequently on the feet, and nobody here has ever seen them on the upper extremities, trunk or face.

This present discussion, and the mention of Pardo-Castello's type of lesion in the paper of Rodriguez and Wade (1940) on bullous tuberculoid leprosy, brings to mind the recent report from Australia of a new mycobacterium which causes ulceration (MacCallum *et al., J. Path. & Bact. 50* (1948) 93). The description of the indolent ulcers agrees in part with Pardo-Castello's type of lesion: absence of any other evidence of leprosy; presence of abundant acid-fast, intracellular bacilli; lack of tuberculoid structure; sloughing down to the deeper structures; pachydermic edema; prevalence on limbs, etc. There was no mention of blister formation in the six cases described, but from Pardo-Castello's description it appears that some of his cases began exactly as did some of the Australian ones. Furthermore, it is possible that racial and nutritional factors may play a part in determining blister formation.

All the evidence considered, there is the distinct possibility that Pardo-Castello was not describing leprosy lesions, but ulceration caused by a different mycobacterium, the one observed in Australia. That point can easily be settled by the use of the cultural and experimental animal technique developed by the Australian workers. That, I think, is essential before any progress can be made in the terminology of these ulcerative conditions and, no doubt, Pardo-Castello will be delighted to undertake such an investigation.

The new mycobacterium has many features in common with *M. leprae*. It is, in my opinion, the nearest organism to the leprosy bacillus yet described, and it is worth investigating from a comparative immulogical and from other points of view. For these reasons, it seems worth while to have the paper reprinted in THE JOURNAL.

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