CORTISONE IN IRITIS

This note is to call attention of leprosy workers to a therapeutic measure which might possibly be of value as a means of relieving an occasional and highly distressing feature of the reactional phase of lepromatous leprosy, namely, acute iridocyclitis. The sulfone drugs have not proved of as much value for this condition as might be desired; for example, Erickson [1] has pointed out that under sulfone treatment the severest type of eye lesions, including iridocyclitis, become definitely worse.

There has been as yet only limited investigation of the effects of cortisone and adrenocorticotropic hormone (ACTH) in leprosy, but indications have appeared that they may be of some value in reactional conditions. Speaking of special drugs under trial at Carville, Erickson has said briefly, "Early results noted from cortisone indicate that it may be of value in lepra reactions and in leprous iridocyclitis." In the article by Roche and associates [2] which appeared in a recent issue of THE JOURNAL, on the beneficial effects of ACTH in lepra reaction, one of the cases recorded had iridocyclitis the symptoms of which subsided markedly during the treatment and "remained practically under control" after the treatment was suspended, although the other reaction manifestations reappeared. Roche remarked, in dis-

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[1] ERICKSON, P. T. The treatment of leprosy. Ann. New York Acad. Sci. **54** (1951) 115-125.

[2] ROCHE, M., CONVIT, J., MEDINA, J. A. and BLOMENFELD, E. The effects of adrenocorticotropic hormone (ACTH) in lepromatous lepra reaction. Internat. J. Leprosy **19** (1951) 137-145.

cussing the paper of Erickson referred to, "A severe iritis which was present . . . disappeared almost entirely and did not return. . . ."

The report to which it is desired to call attention is a brief one by Koff and associates [3] on the effects of subconjunctival injections of cortisone in iritis. For the technique and other details the original article should be read.

Of nine cases of the acute or acute recurrent condition, eight showed remarkable and rapid improvement. In two cases with bilateral iritis in which only one of the eyes was treated, the condition in the untreated eye of one case remained stationary and in the other it became worse, while the treated eyes of both patients improved rapidly. Six cases of chronic granulomatous uveitis were similarly treated. They had previously been treated with ACTH in adequate dosage for 6 to 10 weeks; three of them had not responded, and the condition in the three that had responded had recrudesced within a few days after cessation of the treatment. Subconjunctival injections of cortisone arrested the inflammation in the hormone-responsive group, only, although reinjections at intervals of one to three weeks have been necessary to maintain remission.

The subconjunctival deposit of cortisone disappears gradually without leaving a visible trace. A point of interest is that decrease of hyperemia (pallor) first appears over and around the cortisone deposit and then spreads outward. There are advantages over systemic administration in that it is inexpensive because of the small amounts of the drug used; there is a depository effect, and the deposit persists for several days and seems to remain active during that time; when reinjection is necessary to obtain effect it is made only after 48 or 72 hours; and there are no systemic side-effects and neither hospitalization nor laboratory follow-up is required. It is emphasized that this treatment does not cure the iritis, but it does change the process from one of an acute increasing inflammation to a low grade, easily controlled, subsiding one. —H. W. Wade