

INTERNATIONAL JOURNAL OF LEPROSY

OFFICIAL ORGAN OF THE INTERNATIONAL LEPROSY ASSOCIATION

PUBLISHED WITH THE AID OF THE
LEONARD WOOD MEMORIAL

Publication Office: School of Medicine, Tulane University,
1430 Tulane Avenue, New Orleans 12, Louisiana
Entered at the Post Office at New Orleans as second-class matter.

VOLUME 20, NUMBER 4

OCTOBER-DECEMBER, 1952

EDITORIALS

Editorials are written by members of the Editorial Board, and opinions expressed are those of the writers.

THE CLASSIFICATION DOCUMENTS AND SYMPOSIUM

In a review of the recent history and present status of leprosy classification which appeared earlier in this department,¹ emphasis was laid on the need of a full understanding, by all leprologists concerned with that matter, of the South American system if an acceptable solution of the present situation is to be reached at the Madrid congress. As an aid to that end, it was stated, we planned to print English translations of some of the basic documents. It was also said that an attempt was being made to obtain a sort of cross section of current views on classification by means of a memorandum that was being distributed, and that a symposium would be prepared from the comments received. Both of those features appear in this issue, and also an original article a draft of which was used in obtaining the material for the symposium, and which has been modified in certain respects as a result of that inquiry.

The South American Classification

Whether or not one may agree with all that is involved in the South American formula, or with all that has been said by its proponents in criticism of the older one which it was intended to replace, one can but admire the spirit and energy with which its originators undertook to broaden the basis and

¹ THE JOURNAL 20 (1952) 110-115 (editorial).

concepts of classification. The resultant has much of merit, and its good features will certainly be preserved. In its entirety, however, there were certain features which made it impossible to employ it in most places. Furthermore, most of its literature is in the Portuguese language, and nothing definitive and authoritative was ever published in English. Even today, it is not well enough understood in English-speaking circles to permit its proper evaluation, or to allow sound conclusions to be reached as to what should be done about it.

It is of the greatest importance that we do not have at Madrid a repetition of what happened at the Havana congress in 1948. That story was related shortly afterward²—a relatively solid phalanx confronting an unorganized group of individuals with varied points of view; loss of time and energy in a none-too-successful attempt to inform the latter about the system which the others supported; a conscientious effort to arrive, in too short a time, at a formula which would be acceptable to the majority and might be generally applicable, the resultant embodying material concessions on both sides; and, finally, the acceptance of the first part of the committee's report by the last plenary session of the congress—perhaps, it may be said, without full appreciation of its implications—but the rejection of the part dealing with subgroupings which was needed to make the rest intelligible, and the lack of which virtually negated the whole effort. In things published since then, and also to be seen in the symposium to be considered shortly, there is ample evidence of misunderstanding of essential features of what was accepted at Havana, due to lack of understanding of the South American classification on which it is based. For these reasons we print in this issue, with the full approval of the Editorial Board, certain key documents in translations which have been scrutinized by Brazilian leprologists.

These are: two editorials published in successive issues of the *Revista Brasileira de Leprologia* in 1939 which announced the new development, from which it will be seen that it started out to give priority to the clinical criterion but promptly shifted to the histological one; a report by L. de Souza Lima made in 1945 which, with extraordinary frankness, called attention to certain difficulties and posed certain questions, evidently creating a furor; the gist of an editorial summarizing the various "replies" to those questions; and, finally, a complete translation of the classification report of the Rio de Janeiro Conference (1946), this being

² THE JOURNAL 16 (1948) 383-386 (editorial).

required because the only one extant in English³ has many omissions and inaccuracies. There also appears in the current literature section a review of an important monograph by L. de Souza Lima and F. L. Alayon which appeared in 1941 but has never been given such notice in an English-language periodical.

The Classification Symposium

The views of correspondents who, individually or otherwise, have contributed comments on the memorandum sent them are summarized, in 23 items, rearranged and condensed in varying degrees, in the correspondence section of this issue. It should be pointed out that none of the proposals (or "propositions") in that memorandum was entirely new, although certain ones were given a different basis or status than they had had before.

Four writers (Arnold, Johansen, Muir and Schujman) registered general agreement with the memorandum, and in three other items (by Basombrio and Fernandez, Rodriguez, and Vegas and Convit) agreement with the first five propositions below was stated; these are counted as affirmative in each instance. That is not done with Lowe's contribution, his acquiescence not being sufficiently specific. The São Paulo workers, unfortunately, are not properly represented. To conserve space in this analysis, symbols are used freely, whether or not they were employed by the contributors.

1. That the essential principles and primary groupings of the South American classification should be maintained is agreed to, specifically or by implication, by a large majority. There are, however, some interesting reservations or variances, a few dissenting opinions, and obvious confusion on one point.

Of the variances, Chaussinand first divides leprosy into benign and malign, and then uses the S.A. groups. (A similar first division into lepromatous and nonlepromatous has sometimes been made.) Gay Prieto and Contreras hold that the disease begins almost exclusively as I and arrange their diagram accordingly. Lara regards the S.A. plan largely satisfactory, it being biological, but complains of its restrictive application—this taken to mean only that more than the three original forms are needed. Pardo-Castello reserves the I group for early cases with a few macular lesions which cannot be assigned on the basis of histology or otherwise to one of the polar types. Vilanova, who has his own terminology, holds that the I form should comprise only the macular cases of doubtful evolution. Fraser's position is uncertain, although the S.A. terms are used.

The disagreements are registered by Cochrane, who holds for a different primary criterion; by Dharmendra, who believes that a better scheme could be derived by reconciling the S.A. and Cairo ones; by Chatterjee, who denies the validity of the "polar" concept because cases "are not polar throughout their whole course," a criticism which ignores an avowed principle of the S.A. scheme; and by de Souza-Araujo on

³ THE JOURNAL 15 (1947) 100-108.

similar grounds and because lepromatous and tuberculoid changes may occur simultaneously.

In some instances it is evidently not appreciated that the I group is restricted to simple macular cases. Cochrane confuses it with the "dimorphous" condition, holding that term preferable to "indeterminate." Dharmendra includes in I both flat macular cases (other than maculo-anesthetic) and borderline ones. Fraser, also, seems to regard the I form as the borderline one, which he distinguishes from simple macular.

Four contributions hold for separation of the old-style maculoanesthetic variety from the "indeterminate." Gay and Contreras have it on a subordinate scale, arising from I but otherwise independent. Vilanova would place those cases in his "reactive" group, whether or not the structure is tuberculoid. Similarly, Dharmendra would put them in the tuberculoid type, holding that the histology is usually of that nature. Cochrane has the form in his "lepromin positive" class, as "maculo-anesthetic tuberculoid (or lepride)." The proposal that this form should be a subgroup of the tuberculoid type was first made, it will be recalled, by the Havana committee (*THE JOURNAL* 16 (1948) 391-2). The Pan-American conferences at Rio de Janeiro (1946) and Buenos Aires (1951) put what is apparently this variety in the I class, the former calling it "neuro-macular" and the latter "maculo-neuritic."

2. That the primary basis of classification should be clinical, (involving of course the bacteriological examination) is overwhelmingly upheld. Unexpectedly, no one holds specifically for the histological criterion, although a few lay much emphasis on that examination.

For example, Pardo-Castello would seem to depend on the histological (plus immunological) examination to determine whether to classify simple macular cases L, T or I, and the same for the placing of P cases. Tiant seems of the same mind, and probably also Vegas and Convit at least with respect to P cases. Vilanova, on the other hand, leans heavily on histology but definitely gives the clinical criterion priority.

Of the two dissenters, Lara says that the clinical criteria are not sufficient for many early cases, and that to depend on them alone would be reverting to the unsatisfactory and confusing old practice; no alternative primary basis is indicated. Cochrane states that all lesions [*sic*] should be classified primarily according to their immunological response, on which basis he tabulates three classes (unnamed) among which one finds no place for the simple macular cases which are negative to lepromin but are not lepromatous.

3. That the histological and immunological criteria should be reserved in classification for subgrouping, the corollary of the preceding proposition, naturally has essentially the same status of approval. Few mention the point specifically, but agreement is definitely implied in nine items besides the seven general ones.

In a few instances, most of them just mentioned, there is uncertainty. Cochrane is in agreement regarding histology but not immunology.

4 & 5. The propositions that previous tuberculoid or lep-

romatous cases in which the skin lesions have receded, (a) without or (b) with polyneuritic manifestations, should not be reclassified as "indeterminate" was set down because some South American workers have done that instead of retaining them in their original classes as "regressed" or "residual."⁴ Apart from the seven in general agreement, only three specifically agree to one or the other of these propositions, but that was probably because the matter was generally regarded as noncontroversial since only a few registered disagreement.

Cochrane and Tiant agree regarding Point 4, and Pardo-Castello regarding Point 5, without mention of the companion points. Fraser says that T may change to I, but apparently because of confusion of the latter with borderline.

Gay and Contreras evidently disagree with respect to L, T and B cases (Point 4), the end-point of which in their diagram is "residual incharacteristic" (IR), but apparently agree with Point 5 since no connections are shown between their PP and PS groups and that end one. Chatterjee, pointing out the difficulty of determining the previous nature of cases seen, holds that T cases—and apparently L also—may arise from I and return to it again.

The most controversial section of the memorandum is the one which dealt with other forms to be recognized: subgroups of the tuberculoid type, and separate polyneuritic and "borderline" groups (in ascending order of importance). Here the general agreements are reduced to four.

6. The situation regarding the recognition of minor, major and reactional groups of the tuberculoid type is confused because of previous lack of distinction between the two chronic (or "torpid") forms and the reactional one. In the first description of the minor and major forms,⁵ which was adopted by the Cairo congress, the major one *included* the reactional phase, although it obviously was not intended *exclusively* for that condition.

(a) Regarding distinction of minor and major forms there are, besides the four general agreements, five others showing the same opinion definitely or implicitly. Six items register disagreement for various reasons, and one is ambiguous.

Chaussinand, Cochrane, Fraser, and Vilanova show their agreement in their tabulations or otherwise. For Badger the only question is whether the distinction will be made uniformly.

Chatterjee disagrees because there may be cases of intermediate de-

⁴ No specific authority for this shift is to be found in the Rio de Janeiro report (1946), except incidentally in an added footnote.

⁵ WADE, H. W. Skin lesions of neural leprosy. I. General introduction. *THE JOURNAL* 4 (1936) 409-430.

gree (which is of course true, here as in any other subdivision by degrees), and to minimize danger of confusion. Gay and Contreras are presumably in disagreement since they make no mention of this distinction. Tiant merely says that the matter is not important.

Vegas and Convit hold that the division is not justified because the major variety is one of the reactional tuberculoid forms, as does the comment of the Brazilian Association. Lara holds for "torpid" for minor tuberculoid and "reactive" for major, while Rodriguez favors the same grouping because of the tendency to confuse the major and reactional varieties.

(b) Regarding the recognition of the reactional tuberculoid condition as a distinct variety, five items besides the four usual ones indicate agreement in one way or another. Four are indecisive, but none is definitely in opposition.

Agreement is seen in Cochrane's tabulation of a "reactional" variety in the "lepromin positive" division; in the diagram of Gay and Contreras; in the statements of Lara and of Rodriguez just cited; and in Chausinand's third division of the T type, although it is called "borderline."

As for the uncertain items, Chatterjee skirts the question; Pardo-Castello says that reactional cases can always be placed as T or L; Fraser holds that all reactional conditions should be recognized, but indicates no distinction by type; and Vilanova would apparently put all reactional conditions under "*brotes agudos*." The Brazilian Association places reactional tuberculoid and borderline together, although its report prepared for the Buenos Aires conference—and adopted by it—shows a reactional variety in the tuberculoid type.

7. The proposals that polyneuritic cases be given special recognition as distinct if, obviously, subordinate groups—primary (i.e., cases with no evidence or history of having had skin lesions) and secondary (i.e., residual from one of the ordinary forms)—proved to be the most controversial of all. Besides the four general agreements there are three others for both forms of the varieties indicated; also two items agreeing to P' but not to P'', and one disagreeing to P' but agreeing to P''. On the other hand, four are in disagreement for both groups, and two regarding P' but without mention of P''. In one instance a general P form would be accepted without subdivisions, and in one the matter is uncertain. This works out as nine definitely for P' and eight against it, and eight for P'' and seven against it.

While in full agreement, Gay Prieto and Contreras use the symbols PP and PS; Dharmendra would prefer the term "neuritic" (N) for the purpose of including cases with local anesthetic areas, which is not within the "polyneuritic" concept; Fraser gives a separate bar for polyneuritic cases in his diagram and recognizes the subdivision. The position of Cochrane is uncertain.

Those agreeing to P' only are Rodriguez, and Vegas and Convit, the latter for cases with inconclusive histological findings.

Arguments against acceptance of the P' group are: that it would be contrary to the essence of the S.A. system (Basombrio and Fernandez, the Brazilian Association, Lara); that the cases are only varieties of the primary classes and should and can be assigned to them (Basombrio and Fernandez, Pardo-Castello, Tiant); and that it would be difficult or impossible really to distinguish such cases (Chaussinand, Lara). Chatterjee, who would accept a P (neuritic, N) form, would not divide it because of various difficulties. Vilanova would apparently put them all in his *reactiva* class.

The main argument against P" is that the cases would best be regarded as varieties of their original classes, presumably as residual (Chaussinand, Lara, Pardo-Castello, Rodriguez, Tiant, Vegas and Convit).

Agreement to P" is based by some on the lack of importance of the original form. Gay and Contreras say that the cases represent the same social problem, which is important; and Vilanova—who created his "*fibrosa*" class for them because they show only "curative fibrosis"—holds that the interest is in the condition of invalidity of the patients and the need for surgical or other treatment to lessen it. Tiant remarks, in passing, that the original form is of no importance with respect to prognosis, infectiveness or treatment.

The matter of biopsy of nerves in these cases comes up repeatedly. Some, including Pardo-Castello, Vilanova, and perhaps Tiant, seem to regard it as something readily or commonly done. Basombrio and Fernandez say that it is justifiable in extraordinary cases, and Schujman recommends it for Mitsuda-negative P' cases (telling of three that were diagnosed as lepromatous from biopsy findings). Gay and Contreras, on the other hand, say that nerve biopsy *should not be practiced* (italics theirs).

8. The proposition that the "borderline" cases, atypical and with features of both the tuberculoid and lepromatous types, should be recognized as a separate group is agreed to by an overwhelming majority. Of nineteen contributory items, seventeen are affirmative, without qualification or with differences regarding status or otherwise.

Regarding the name, "borderline" (including *limitantes* or *limitrofes*) is used by most. Cochrane and Rodriguez prefer "dimorphous," while Arnold says that "borderline" conveys the idea of instability and uncertainty of status better than others used, although "dimorphous" has merit. Vilanova labels it both "intermediate, borderline (I)" and "borderline (I?)."

Of those in agreement with the proposition, Badger suggests the possibility that the borderline form may be confused by some with the indeterminate one. Gay and Contreras hold for a B group nearer L than T (see diagram). Rodriguez speaks of a wide zone between the polar forms comprising atypical cases with variable degrees of admixture. Cochrane recognizes the group, but its position in his system is difficult to understand; his tabulation shows "atypical tuberculoid" and "atypical leproma" forms, also speculative dimorphous macular and polyneuritic forms and apparently a reactional one. That de Souza Lima was inclined,

as far back as 1945, to recognize a borderline group is evident from his *Tres Corações* report.⁶

Of those not according this group an independent status, Basombrio and Fernandez believe it should be included in an "indeterminate reaction" group (Fernandez); Chaussiand's table has a borderline subgroup in the tuberculoid type; Fraser includes it in his "reacting skin lesions" level; Dharmendra has it as a division of his conception of the indeterminate form; the Brazilian Association combines borderline and reactional tuberculoid cases; and Lara would divide these cases into an "intermediate ('borderline') lepromatous" (IL) group located between "undifferentiated" and L, and an "intermediate ('borderline') tuberculoid" (IT) group between "undifferentiated" and T.

Both of the two items not in agreement seem ambiguous. Chatterjee, after listing B among the five groups to be recognized, says that "for all practical purposes [these cases] would better be called lepromatous whatever may be their histology." Pardo-Castello says that reactional cases can always be placed as tuberculoid or lepromatous, although a few of the former may change to lepromatous, and rarely the reverse change may occur.

In this symposium there is ample support for the remark of Rodriguez that ". . . it seems that the experience of most leprologists does not permit them to accept without modification the classification of others . . ." The situation that Lowe envisioned, in which leprologists might in some way be controlled, with the stifling of originality of thought and cessation of advances in knowledge, seems unlikely to develop. We submit that there would be material benefit if a substantial majority of leprologists should now agree on such basic principles of classification as are permitted by present knowledge and from them arrive at a generally applicable formula. No one can expect that the final answers to all of the problems can be attained at present, or that all cases of leprosy encountered will fit neatly into any systematic scheme. It should, however, be possible to improve greatly the present situation, in which many still adhere to the essentials of the Cairo classification or attempt with dissatisfaction to apply what was approved at Havana.

—H. W. WADE

⁶ See the Reprinted Articles section of this issue.