CORRESPONDENCE

This department is provided for the publication of informal communications which are of interest because they are informative or stimulating, and for the discussion of controversial matters.

CLASSIFICATION AT MADRID

To The Editor:

I have read with interest the report of the Classification Committee of the Sixth International Congress of Leprology held in Madrid in October 1953.[1] It is gratifying to note that, regarding the criteria of primary classification, the Committee fully endorsed the following statement of the WHO Expert Committee on Leprosy expressed at its first session at Rio de Janeiro in November 1952:[2]

> The committee agrees unanimously that the basic criteria of primary classification should be clinical, comprising the morphology of the skin lesions and neurological manifestations. Indispensable in connexion with the clinical criteria is the bacteriological examination of smears of skin lesions and the nasal mucosa.

One finds, however, that when making actual recommendations regarding primary classification it is really the histopathological criterion that has carried most weight with the Committee. Otherwise, how could one explain the recommendation that flat, hypopigmented patches generally known as "simple macular" or "maculoanaesthetic" patches be included under the "tuberculoid" type? Since that term came into use it has usually been applied to more or less thickened patches or lesser lesions which show various degrees of elevation, and that is what comes to mind when the term is seen. The inclusion of the two morphologically different kinds of lesions under that designation can be justified only when histology is considered the basis of primary classification, since low-grade tuberculoid changes are found in a large proportion of these flat patches.

I may add that I am in full agreement with the note of dissent appended to the report of the Committee regarding the inadvisability of including the "simple" flat macules in the same class with the elevated "tuberculoid" lesions, and regarding the confusion in terminology likely to be caused by the creation of the term "macular tuberculoid."

On the other hand, in the Madrid classification the purely polyneuritic cases with similar clinical manifestations are split up into lepromatous, tuberculoid, and indeterminate according to the probable histopathological structure of the affected nerve trunks. In some of these cases the nature of the underlying pathological process may be indicated by results of the lepromin test, but in others it may remain obscure without biopsy of the

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[1] The Journal **21** (1953) 504-510.

[2] W.H.O. Expert Committee on Leprosy. First report. World Hlth. Org. Tech. Rep. Series No. 71, September 1953.

nerve trunk, which procedure is generally considered inadvisable and is in fact often not practicable.[3] The splitting up of cases with common clinical findings in this classification cannot be said to be based on clinical criteria.

The views expressed above are in keeping with the conclusions of the Classification Committee set up by the Indian Association of Leprologists in the beginning of 1953. These views are contained in an article by Dharmendra and Chatterjee in the October 1953 issue of *Leprosy in India,* and a symposium in the same issue based on replies from members to whom the draft article was circulated as a working document.

Leprosy workers are in general agreement with regard to the nature of histopathological changes seen in the various kinds of leprous lesions. The present writer subscribes [4] to the generally held view that in leprosy there are seen four main types of histological reactions: (1) lepromatous, (2) tuberculoid, (3) simple, indeterminate, or uncharacteristic, and (4) borderline or dimorphous. The real difficulty comes when it is attempted to group all the clinical manifestations of leprosy under these histological types, or, in other words, when the histological reactions are used as synonyms for clinical types, as has been done in the recommendations of the Classification Committee at Madrid.

The difficulty increases when such a classification is said to be primarily based on clinical criteria. It would have been easier to appreciate the recommended classification if it had been stated that classification in leprosy should be based mainly on histopathological grounds, or in other words, on the underlying pathological processes. It is difficult to reconcile the unanimous agreement of the Committee regarding the clinical features forming the basic criteria of primary classification, with the classification actually recommended by the majority of it, which is really based on histological criteria.

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TO THE EDITOR:

1. The classification of leprosy as adopted at the Sixth International Congress of Leprology held in Madrid last year is certainly a step in the right direction. It seems a pity, however, that under "tuberculoid" there has been included a subgroup termed "tuberculoid macular," particularly so in view of the fact that the classification is supposed to be based primarily on clinical findings.

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[3] How little practiced is nerve biopsy is shown in a symposium in THE JOURNAL **21** (1953) 242-249. A great majority of the contributors did not practice it or were definitely against it.

[4] DHARMENDRA. A note on the histopathology of leprosy. *Lep. India* **21** (1949) 92-96.

First, although there may be a few macules that could be so classified on morphological grounds alone, the greater number of such lesions would need histological assessment to prove whether they were of tuberculoid nature or indeterminate. Secondly, the tuberculoid lesion has all along been associated with a characteristic morphology, thus the term "tuberculoid macular" may tend to confuse matters.

If histological and immunological criteria are always to be considered in classification, it would be consistent and logical to divide nonlepromatous macules into indeterminate and tuberculoid. However, for the leprosy worker who does not have the facilities for these two procedures, it would be better to lump all nonlepromatous macules as indeterminate, giving a meaningful description of the lesion.

Incidentally, the macular tuberculoid lesion is described as being smooth and dry. A dry lesion is usually rough. I presume what was meant was, it is flat and dry.

2. Although I believe that, with sufficient experience, a pure neuritic form of the lepromatous variety can be differentiated clinically from the pure neuritic of the tuberculoid variety, this differentiation can really be made definitively only from the result of the lepromin reaction, or by nerve biopsy.

3. In the description given for borderline (dimorphous) cases it is said, "this group may arise from the tuberculoid type as a result of repeated reactions and sometimes evolves to the lepromatous type." This appears to me to be a most inconsistent statement, particularly in view of the fact that polarity, as far as the two types were concerned, was so greatly emphasized. To quote again:

> Type connotes clinically and biologically stereotyped features, characterized by marked stability and mutual incompatibility.

If it is accepted that the tuberculoid type is stable and is evidence of tissue immunity (a high degree of sensitization to the antigen), then it cannot follow that reactions of tuberculoid lesions, which we must accept as a sign of tissue immunity or sensitization, lead to either borderline or lepromatous change.

The classification as proposed by the WHO Expert Committee on Leprosy, seems to me to be one that could be accepted by workers everywhere.

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[It would be interesting to know how prevalent is the feeling about the feature of the classification scheme adopted at the Madrid Congress, discussed by our two contributors, who are experienced leprologists working in widely separated parts of India. That one member of the committee was firmly opposed to the inclusion of cases with any kind of clinically simple macules in the tuberculoid type is seen from the adden-

dum to the committee's report, but it is significant that there is no co-author of that dissenting opinion.

[The suggestion is offered by Dr. Gass that the classification proposed by the WHO Expert Committee on Leprosy might be used, instead of the Madrid formula. This raises the question of how widely available that report may be. Rather belatedly, we are running in this issue a review of it, but that is only an indication of what it contains. Inquiry will be made as to the permissibility of our reprinting in full the section on classification.

[As for the third point of Dr. Gass, his objection evidently arises from a difference of conception of the *degree* of stability of the polar types. The idea of absolute stability, or fixity, in leprosy would be hardly consistent with what is seen in the mass. The fact that an occasional case of tuberculoid leprosy may, as a result of repeated severe reactions, change to the borderline condition—is in the opinion of many—beyond dispute.—EDITOR.]