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EDITORIALS

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HITHERTO UNNOTED FEATURES OF "BORDERLINE" CASES - Editorial

Knowledge of that class of leprosy case which has a status somewhere between frank tuberculoid and typical lepromatous is decidely imperfect. Even recognition of the simple fact that there are many such cases spread only slowly after the first publications on the subject.[1] The classification scheme of the Second Pan-American Conference in 1946[2] touched on the matter only in a footnote, which says that one of the reactional varieties of the tuberculoid type may, by "progressive evolution, transform to the lepromatous type." The classification committee of the Havana Congress[3, 4] was too concerned with other problems to deal with this one, not yet regarded as important.

The Third Pan-American Conference held in 1951,[5] which attempted to provide subdivisions of the forms adopted at Havana, recognized that in the reactional tuberculoid subtype there are cases of borderline

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[1] WADE, H. W. and RODRIGUEZ, J. N. Borderline tuberculoid leprosy. Internat. J. Leprosy **8** (1940) 307-332. COCHRANE, R. G. Development of the lesions of leprosy with particular reference to tuberculoid leprosy and the significance of the lepromin test. Ibid. **8** (1940) 445-456. WADE, H. W. Relapsed and borderline cases of tuberculoid leprosy. Leprosy Rev. **12** (1941) 3-17.

[2] CONFERENCE, II PAN-AMERICAN (Rio de Janeiro, 1946). Report of the Committee on Classification. Internat. J. Leprosy **20** (1952) 505-512 (new translation).

[3] CONGRESS, V INTERNATIONAL (Havana, 1848). Technical resolutions. Classification and nomenclature. Internat. J. Leprosy **16** (1948) 201-204.

[4] [CONGRESS, HAVANA] Classification at the Havana Congress, Portion of the report of the classification committee rejected by the final plenary session. Internat. J. Leprosy **16** (1948) 391-397.

[5] CONFERENCE, III PAN-AMERICAN (Buenos Aires, 1951). Report of the Committee on Classification of Subtypes. Internat. J. Leprosy **20** (1952) 263-266.

(*limitrofes*) nature which "present aspects of transition toward the lepromatous form," and these cases were described at some length. It was suggested that it should be determined at the Madrid Congress whether or not a distinct group should be created for them. This was done first by the WHO committee which met in Rio de Janeiro in 1952,[6] and in due course the Madrid Congress concurred.[7] In these sources the descriptions are necessarily very brief.

Nowhere is there available, so far as we are aware, an adequate exposition of this class of case. There is reason to believe that in the minds of different leprosy workers, even those who are especially interested, the pictures of it vary widely. Any information about the condition that will help to clarify and fix the picture would be welcome. Two points mentioned in recent articles seem worth bearing in mind.

From the experience of many workers in the period when various dyes were being tried out in leprosy therapy, it is known that after repeated intravenous injection of methylene blue in lepromatous cases the skin lesions become colored, so that even "inapparent" lesions are made evident, because of selective absorption of the dye by the lepra cells. On the other hand tuberculoid lesions remained uncolored, the cells which compose them lacking the capacity to store dyes. Montel, in his article in this issue of THE JOURNAL, tells of cases with both tuberculoid and lepromatous lesions, the former uncolored by methylene blue, the latter intensely stained by it; and a photograph is presented to demonstrate this condition. This statement suggests a new means for the study of borderline cases, one by which anyone who can give the necessary course of injections might obtain help in differentiating between the severe reactional tuberculoid case that has not gone over and may be expected to subside to the quiescent phase, and the case whose lesions have actually begun to go over the border to the lepromatous region of the spectrum.

Another point of interest is the recent report of Hale, Molesworth and others[8] on isoniazid treatment. A large proportion of the cases studied were of an "atypical" class, "more or less of the order of what is called 'borderline' by some workers." They stated that erythema nodosum leprosum occurred in many of the lepromatous and atypical cases, especially if the dosage was high. Now, it is generally recognized that that type of reaction is a characteristic of lepromatous cases but not of tuberculoid. That being true, if follows that if a borderline case under treatment

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[6] WORLD HEALTH ORGANIZATION. Expert Committee on Leprosy. First Report. WHO Tech. Report Series No. 71, 1953, pp. 28.

[7] CONGRESS, VI INTERNATIONAL (Madrid, 1953). Technical resolutions. Classification of Leprosy. Internat. J. Leprosy **21** (1953) 504-516; Mem. VI Congr. Internac. Leprol., 1953; Madrid, 1954, pp. 75-86.

[8] HALE, J. H., MOLESWORTH, B. D., RUSSELL, D. A. and LEE, L. H. Isonicotinic hydrazide in the treatment of leprosy. Internat. J. Leprosy **22** (1954) 297-302.

develops this reaction, it has gone pretty far in its essential character to the lepromatous side. It is suggested that observations on this point should be recorded. —H. W. WADE

TUBERCULOID LEPROSY AS THE PRIMARY FORM

The article by Dr. M. L. R. Montel in this issue of THE JOURNAL is avowedly an individualistic product. While some of the opinions expressed are in agreement with those of many others—notably that neither the histology of the lesions nor the result of the lepromin test is satisfactory for the primary criterion of classification—other opinions are contrary to those that have become widely accepted, some of them as "official" as they can be made by the WHO'S Expert Committee's report and the action of the Madrid Congress. The article is frankly controversial, and was accepted for publication subject to this comment. The author agreed and said, "J'estime que l'interêt de mon travail est justament dans son caractère personnel de non conformism."

Montel's primary thesis is that leprosy almost always begins as tuberculoid, although sometimes transformation to lepromatous occurs so soon that the original form is not observed. In support of that opinion he says that in Saigon he found 80 per cent of the children brought to the clinics were tuberculoid, and that in Paris all of 14 leprosy cases were or had been tuberculoid.

That many cases of leprosy which are lepromatous today were not of that type at the outset is hardly to be disputed, but the opinion that virtually all began as tuberculoid is certainly open to question. Disagreement may be expected especially from field workers who search out the earliest cases among children and others in their schools and homes. They see many early lesions that could not be called tuberculoid by any accepted criteria. South American workers see so many such cases that they set up the long-since accepted "indeterminate" (originally *incaracteristico*) group to take care of them in classification. It is generally agreed that some proportion of this "unstable" variety will evolve directly to the lepromatous end of the spectrum, not passing through a tuberculoid phase.

But Montel flatly disavows the indeterminate group. Furthermore, he so broadens the concept of tuberculoid that it becomes hardly recognizable. Pure nerve lesions without skin lesions are tuberculoid, he holds, as are flat macules of centrifugal extension.[1] At the other extreme the "borderline" and related cases are included, but these are hardly *formes de début*.[2]

To digress for a moment, it would not have been unexpected if, when he mentioned the children seen in Saigon, he had pointed out that many primary tuberculoid lesions in such individuals disappear spontaneously,

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[1] In this last Montel appears to be in agreement with the majority of the Classification Committee of the Madrid Congress.

[2] In his tabulated scheme of classification these cases are not included in the tuberculoid form, but in an intermediate one.