

In this issue are several contributions, arranged alphabetically by countries, received in response to the questions raised in a letter from Dr. Felix Sagher, of Jerusalem, printed in the last issue. These questions refer to (a) the significance in contact children of pale macules that

disappear, and the permanence of the subsidence; and (b) contacts that are found bacteriologically positive but are without skin lesions. There are things about certain of the contributions to this symposium that should convince anyone that he is in error who has thought that clinical leprosy no longer poses any challenging problems.

After the impermanent, hypochromic macules in children, more than one contributor counsels caution in diagnosing them as leprotic in the absence of cardinal signs, recognizing the difficulty of detecting disturbances of sensation in young children. As Rodriguez puts it, their importance is as an indication that those children should be watched. In Lara's experience at Culion many are of tuberculoid histology in some degree, whereas in the experience of Rodriguez, and apparently also of Convit, the banal chronic round-cell infiltration is usual. In some quarters the histamine test seems to be ignored, despite its usefulness in all but the darkest skins; only the contributors from South America and Spain mention it. That test could surely be applied to the most obstreperous, fractious child without permanent injury to his psyche and without contributing to subsequent juvenile delinquency. Bacteriological examination by chloroform extraction of a small biopsy specimen would be more drastic, but from the reports of results obtained thereby it evidently should be done where possible.

No one points out that it is fully twenty years since—naming them in alphabetical sequence—Cochrane in Madras, Lara at Culion, and de Souza Campos and de Souza Lima in São Paulo began observing untreated children with lesions the great majority of which disappeared, apparently permanently. Most of those lesions, however, were of the frank tuberculoid of childhood form, and Sagher refers only to the simple, flat hypopigmented macule which disappears, and that would be of the indeterminate class. Apparently one cannot be so confident that such lesions—when proved leprotic, as in older children—will clear up. No one suggests a possible difference in prognosis between cases with solitary and with multiple lesions, or points out that if they are multiple and hazy there is reason for concern lest they turn lepromatous, although Dharmendra tells of a case apparently of that kind.

It would be difficult to draw from these contributions a conclusion about whether or not children whose macules have disappeared should be given treatment—a question not asked by Sagher. Apparently Rodriguez would see no need for doing so whereas evidently Convit would, at least if the lesion could be diagnosed as leprotic. Dharmendra indicates reluctance to submit anyone to prolonged treatment with the toxic sulfones unless there is evident need for it.

As for the question of contacts with positive bacteriological findings but without skin lesions, there is evidenced an amazing situation. Sagher says he has five certain cases and has put these under treatment. Convit speaks vaguely of a very few cases seen, too few to permit discussing

the matter. Contreras and Guillen merely indicate that carriers are theoretically possible but are probably infrequent, with no statement that they have dealt with actual cases. Rodriguez and the São Paulo writers say frankly that they have had no experience of such cases; and Lara, presumably for that reason, avoided that question entirely.

That leaves only our contributors from India, where this matter seems to be highly controversial. The work that Desai and associates on the Bombay side have done is without parallel, except for smaller-scale check investigations by Dharmendra on the Calcutta side, and the results they report are equally unparalleled. No less than 610 out of 1,852 contacts examined (33%) were found to be without skin lesions but bacteriologically positive. That was almost one-half of those who had no leprosy skin lesions—and their improved method of obtaining the bacilli has been used only since 1952. Dharmendra has confirmed the finding that acid-fast bacilli may sometimes be gotten from individuals without skin lesions, but in a smaller proportion. Nowhere else, to our knowledge, has there been an investigation of this sort on a scale that would be contributory.<sup>1</sup>

No less astonishing are the results of the Bombay workers with the lepromin test in contacts—bearing in mind that they were not limited to children. It appears that of 610 bacteriologically-positive, lesion-free contacts all were lepromin positive except 14 children, whereas the 656 not found bacteriologically positive were all lepromin negative. Dharmendra did not find this sharp distinction. Nor do these findings agree with the several reports over the years showing that fairly large proportions of persons in leprosy-free regions will react positively, or with general experience elsewhere among healthy individuals. There would seem to be some factor in Bombay that differs from other places.

Be that as it may, the question of the detection of no-lesion carriers among contacts and what should be done with them remains an open one. It seems likely to be so for some time to come, certainly until it is taken up energetically in other parts of the world, where there are many subjects and adequate facilities.

—H. W. WADE