CORRESPONDENCE

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THE "ACUTE INFILTRATION" REACTION OF LEPROMATOUS LEPROSY

To The Editor:

Replying to the questions asked when you sent the revision of my abstracts [see the Current Literature section of this issue] I have no objection to the explanation in the footnote to the second one. The use of "macular" in Japan in the same sense as "tuberculoid" is merely a matter of custom; we have no preference for it, so I agree to the use of "neural-tuberculoid" in the abstracts.

The term *"akuter Schub"* has long been used in this country for reactions in tuberculoid cases, and I used it several times. When I tried to translate it into English I had difficulty ("acute rash," "acute relapse"), and if the original term will be best understood because of previous usages it may be used throughout.

As for the syndrome of "acute infiltration" described in my two reports, I have been collecting cases since 20 years ago, when I first noticed this phenomenon. The most noteworthy points are:

1. It is an acute reactional condition which resembles erysipelas or the *"akuter Schub"* of tuberculoid leprosy.

2. It usually occurs late in the resorption stage of lepromatous leprosy, when nodules or infiltrations are subsiding. Occasionally, however, it happens in an early stage of that type.

3. The "borderline" condition that you write of, resulting from repeated, severe *akuter Schub* in the long process of tuberculoid cases, is quite different from the condition I dealt with in my papers.

4. The "borderline" is a stage where a tuberculoid case shifts toward or to the lepromatous type. The "acute infiltration" of my treatise, on the other hand, is the phenomenon by means of which a case of lepromatous type changes to a form with more favorable prognosis, often ending up in the secondary neural condition.

5. "Acute *lepromatous* infiltration" is another matter. It means a sudden turning for the worse of the nodular or infiltrative lesions of patients of lepromatous type—an unfavorable change, and not a favorable one as is the "acute infiltration."

6. Frequently—and this is a very important and significant fact—the reactivity to the Mitsuda test changes from negative to positive with this condition as the turning point, and the positivity so induced last for a long time.

7. Although before the reaction the case is clearly of lepromatous type, clinically and histologically, the skin lesions come to present a tuberculoid histology afterward.

8. These cases tend to occur more and more frequently with the recent spread of chemotherapy.

9. In the Japanese language we call this condition kyusei shinjun, whereas the banal acute lepromatous reaction is called kyusei raishusei shinjun. In rendering these terms into English as "acute infiltration" and "acute lepromatous infiltration," respectively, there is admittedly so little difference that they are liable to be confused. If a more distinctive and appropriate term can be devised for the condition which I have studied so long, I shall be glad.

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TO THE EDITOR:

On examining the Japanese text of Tajiri's articles about which you inquire, it is obvious that the term "maculoanesthetic" was used in the sense of "macular," or tuberculoid, and neural forms. In Japan now, I think, "maculoanesthetic" usually applies to cases with lesions that are not infiltrated, not erythematous or only slightly so, and are more or less depigmented, usually somewhat well-defined, and anesthetic. This form and the "pure neural syndrome" constitute the "neural type" of the classification of the Japanese Leprosy Association which we (Hayashi and Kitamura) presented at the Madrid congress.

In Japan at present we *do not dislike* the term "tuberculoid." Indeed, many Japanese leprologists would now use it in place of "macular."

Regarding the reference in Tajiri's abstract to the borderline condition—referring to the form which was recognized in Madrid—the statement that "the acute infiltration belongs to the borderline group" seems not adequate. Tajiri undoubtedly wanted to establish the fact that this acute infiltration condition is one which means a passing improvement of lepromatous leprosy. Based on the Mitsuda reaction and other findings, including the histological, the condition is the *direct opposite* of the transition of tuberculoid leprosy to borderline.

The following is a translation of the conclusions of Tajiri's article. The quotation marks have been added.

(*a*) "Acute infiltration" is a passing acute syndrome which may appear in lepromatous leprosy, either in an early stage or after long duration when the lesions are undergoing resorption. There are an erysipelas-like exanthem and infiltration, fever of 37°-39°C, and joint pains.

(*b*) The lesions of "acute infiltration" present histologically a tuberculoid structure. While they contain more leprosy bacilli than the acute reactional lesions of tuberculoid leprosy, they have very much fewer than are in the ordinary lepromatous infiltration. The histological features are entirely different from those of that infiltration.

(*c*) In many cases of "acute infiltration" the Mitsuda reaction changes from negative to positive and then remains positive for a long time. Cases are known that have remained positive for twenty years. The degree of positivity, however, is weak as compared with the reactions in tuberculoid cases.

(*d*) In many instances the disease becomes mild after the appearance of this "acute infiltration," and it remains milder for a variable length of time; and with that the prognosis becomes better.

(*e*) The "acute infiltration" of lepromatous leprosy can be differentiated from the acute aggravation of the neural-tuberculoid forms, from the erythema nodosum leprosum of lepromatous leprosy, and from the acute aggravation of that type.

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TO THE EDITOR:

Referring to the abstracts of articles by Dr. Tajiri on the "acute infiltration" type of reaction in lepromatous leprosy, I recall that in the discussions of the committee that dealt with the subject during the Leonard Wood Memorial conference in Japan in 1952 I told the Japanese members that we in the Philippines do not see among the lepromatous cases in the leprosaria the clinical picture that they described, but that we do see a very similar condition in the dispensaries among our *tuberculoid* patients. I did not interpose any objections to the inclusion in our report of this type of acute lepra reaction as it was differentiated from erythema nodosum leprosum, but I did say informally that it is not of particular interest to us because it is not seen in our leprosaria.

As for my own opinion about this condition I have no well-established views, for one thing because of its infrequence and also because I have not yet seen a case tested with lepromin before the reaction. One of Tajiri's main points is that they are lepromin-negative before the reaction but positive afterward. We have recently had in our clinic a typical case in which the reaction was 1+ after the reaction had subsided; there had been no test before that.

I have seen typical cases of "acute lepromatous infiltration" only in the leprosaria of Japan and at Carville, in Louisiana, although Davison says that they also have plenty of them at Pretoria. It seems probable that was the "red face" of the Carville patients, much dreaded because of the severe constitutional symptoms in some cases, and the liability of developing paralysis of facial muscles.

The condition was seen before the sulfone era, but I believe they became much more frequent after the introduction of Promin. It occurs to me that there is one thing in common in these three places—although it should probably be said that it *was* common to them—and that is the general use and perhaps over-use of that drug. I suspect this type of reaction occurs chiefly among lepromatous cases with diffuse, faint infil-

trations, that are over-treated with promin or that receive that drug for long periods of time.

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