INTERNATIONAL JOURNAL OF LEPROSY

VOLUME 24, NUMBER 1 JANUARY-MARCH, 1956

CLASSIFICATION OF LEPROSY IN JAPAN

REPORT OF THE CLASSIFICATION SYMPOSIUM OF THE JAPANESE LEPROSY ASSOCIATION

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I. INTRODUCTION

At the 27th annual meeting of the Japanese Leprosy Association (J. L. A.), held in Tokyo in April 1954, Dr. T. Yamamoto was elected president for the 28th annual meeting to be held in Kyoto in April 1955, as Section 35 of the 14th Japan Medical Congress. He planned as one of the main events of the meeting a symposium on classification, and appointed the senior author as chairman of the symposium; and he in turn co-opted the other of us to assist in preparing for it. To that end Nishiura prepared a questionnaire for the members of J. L. A. and collected the answers for purposes of reference. Kitamura, after consultation, selected eight persons to be principal speakers and six others for additional speakers at the symposium, and other preparations for it were made during the year.

II. HISTORICAL

To review briefly the history of classification of leprosy in Japan, the first point to be noted is that the disease has long been regarded as consisting of three clinical types. At first and for many years these were called nodular, macular and neural. Recently, however, terms in more general use have been employed: lepromatous, tuberculoid and neural. The neural type comprises two subtypes: the pure neural form, and the simple macular, or maculoanesthetic, or hypochromic form.

During the last several years, various atypical forms have also become more and more an object of interest in Japan. It has not yet been determined, however, what positions in classification should be set up

for them. Consequently, in the classification proposed by Hayashi and Kitamura in the name of the J. L. A. at the Madrid congress in 1953, they were placed temporarily outside the three main types, as transitional and borderline cases. What the Japanese leprologists now think about these atypical forms will be seen later.

The main feature of the J. L. A. classification proposed at Madrid was the preservation of the neural type as a clinical unit. In other words, it was proposed to restore the neural type of the Manila (1931) classification, modified at Cairo (1938), in place of the "*incaracteristico*" or "indeterminate" group of the classification adopted at Rio de Janeiro (1946) and Havana (1948), and further discussed at Buenos Aires (1951).

An investigation by the Japanese Ministry of Health and Welfare in 1951 showed that among 8,791 leprosy patients in the ten national leprosaria there were 2,458 cases classified as lepra nervosa—28 per cent of the total. These cases would really include those which correspond to neuritic varieties of the lepromatous and tuberculoid types of the Latin-American classification and the one adopted by the Madrid congress. However, we cannot determine by clinical means alone what kind of histological changes—lepromatous, or tuberculoid or simple chronic inflammatory—actually exist in the nerves of such cases. That is why we attempted to reestablish the neural type and to put into it cases which have clinically no skin lesions, only neurologic changes such as localized anesthesia and palpable enlargement of nerve trunks. In our classification, we would assign these cases to a pure neural form. Cases which present nonerythematous, depigmented and anesthetic macules, irrespective of the type of inflammatory lesions which preceded them, should also be placed in this neural type and would be called the hypochromic form. Cases with erythematous, more or less well-defined anesthetic macules would, in our classification, fall into the tuberculoid type, because such lesions histologically must be of tuberculoid nature.

Thus, we would again have acknowledged the neural type as a clinical unit of leprosy. And we placed this neural type on a par with the other two types showing more manifest skin lesions, the lepromatous and tuberculoid types. The J. L. A. classification proposed at the Madrid Congress was as follows:

I. Lepromatous type (bacillus positive, Mitsuda negative):
   1. Lepromatous macules and plaques;
   2. Diffuse infiltrations;
   3. Papules and nodules.

II. Neural type (bacillus negative, Mitsuda positive):
   1. Pure neural form;
   2. Hypochromic form.

III. Tuberculoid type (bacillus negative or positive, Mitsuda positive):
   1. Tuberculoid macules, plaques and papules;
   2. Circinate form.

Transitional cases.

Borderline cases.

Lepra reactions:

1. Erythema nodosum leprosum;
2. Acute lepromatous and tuberculoid infiltration;
3. Acute neurologic syndrome.

In this classification, cases belonging to the pure neural or the hypochromic form of the neural type would be determined as lepromatous or tuberculoid and transferred to the corresponding type only when such changes in the nervous tissues or the skin lesions are determined histologically. But, so far as the clinical features are concerned, they are treated as pertaining to the neural type.

Furthermore, it is not only for convenience in clinical classification, but also because of the generally very stable and "determinate" nature of such neural cases that we would maintain the neural type as a definite clinical unit. However, although neural cases usually react positively to the Mitsuda test, there are nevertheless a few exceptional ones which are Mitsuda negative and therefore to be regarded as being of more unstable nature. Nishiura has proposed calling such cases the indeterminate stage of the neural type, which would recognize that some of the neural cases are unstable or indeterminate in their nature.

Theoretically, leprosy can be divided into only two kinds: lepromatous and nonlepromatous, with characteristic histological features and mutually inverse characteristics with respect to bacteriology and the Mitsuda reaction. The late Fumio Hayashi held for this classification.[1]

III. NISHIURA'S QUESTIONNAIRE

The answers from 54 of the 305 members of the J. L. A. to Nishiura's questionnaire are summarized as follows:

I. Question: Which criterion or criteria do you prefer as the main basis of classification: clinical features with bacteriological findings, or the lepromin reaction, or the histopathological picture? The answers:

1. Clinical features ..... 15 = 31%
2. Clinical features plus lepromin reaction ..... 9 = 18%
3. Clinical features plus histopathological picture ..... 2 = 4%
4. Clinical features plus lepromin reaction and histopathological picture ..... 15 = 30%
5. Lepromin reaction ..... 1 = 2%
6. Lepromin reaction plus histopathological picture .... 1 = 2%
7. Histopathological picture ..... 7 = 14%

II. Queston: What do you think of the J. L. A. classification proposed at the Madrid Congress? The answers:

1. Can be accepted unconditionally ..... 15 = 31%
2. Can be accepted after some amendment ..... 31 = 63%
3. Cannot be accepted ..... 3 = 6%

[1] At our symposium, as will be seen, Abe, Onishi, Tajiri and Hayashi also favored dividing leprosy in these two main types, the nonlepromatous one to have two subtypes, neural and tuberculoid.

III. Question: What do you think of the Madrid classification? The answers:

1. Can be accepted unconditionally ..... 0 = 0%
2. Can be accepted after some amendment ..... 24 = 54%
3. Cannot be accepted ..... 20 = 45%

It is seen from these answers that there is recognition of the importance of the immunological and histopathological criteria, besides the clinical criterion. As for the J. L. A. and the Madrid classifications, it is clear that the amendment of both of them is desired by the leprologists of Japan.

IV. THE 1955 SYMPOSIUM

The classification symposium was held, as planned, at the 28th annual meeting of the Japanese Leprosy Association in Kyoto, on April 3, 1955. Dr. K. Kitamura, professor of dermatology, University of Tokyo, served as chairman, and Dr. M. Nishiura, associate professor of dermatology, University of Kyoto, as secretary.

The eight principal speakers were: Dr. H. Abe, director of the Matsuoka-hoyoen National Leprosarium, Aomori; Dr. M. Namba, of the Ogu-komyoen National Leprosarium, Okayama; Dr. Nishiura; Dr. K. Onishi, director of the Hoshizuka-keiaien National Leprosarium, Kagoshima; Dr. K. Saikawa, of the Nagashima-aiseien National Leprosarium, Okayama; Dr. S. Sato, chief researcher in leprology, Institute for Tuberculosis and Leprosy, University of Tohoku, Sendai; Dr. I. Tajiri, of the Tama-zenseien National Leprosarium, Tokyo; and Dr. Sh. Takashima, director of the Suruga-ryoyosho National Leprosarium, Shizuoka.

The six additional speakers were: Dr. T. Hashimoto, ex-professor of dermatology, University of Niigata; Dr. Y. Hayashi, director of the Tama-zenseien National Leprosarium, Tokyo; Dr. T. Nojima, director of the Oshima-seishoen National Leprosarium, Kagawa; Dr. K. Mitsuda, director of the Nagashima-aiseien National Leprosarium, Okayama; Dr. Miyazaki, director of the Kikuchi-keifuen National Leprosarium, Kumamoto; and Dr. T. Tanimura, ex-professor of dermatology, University of Osaka.

In opening the symposium Kitamura reviewed all of the classifications ever published. He also expressed regret for the absence of Dr. R. G. Cochrane, who had been expected to speak at the general session of the congress on "A Critical Appraisal of the Madrid Classification of Leprosy" and also to attend the symposium, but who had had to be in Korea at the time. The opinions of the several speakers[2] are arranged here, in an order that differs slightly from that of the list that was given out at the meeting, under the following six headings: (1) classification proposed; (2) classification of reactional phases; (3) opinion on the neural type of the J. L. A. classification; (4) opinion on the indeterminate group of the Havana classification; (5) opinion on the borderline group of the Madrid Classification; and (6) other opinions.

1. *Dr. Abe's proposals and opinions:*

I. Lepromatous type.

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[2] Items numbered 1 to 8 are the contributions of the principal speakers, those numbered 9 to 14 are the contributions of the additional speakers. At the symposium itself the latter had to be omitted for lack of time.

II. Maculoneural type.

III. Atypical group.

The indeterminate and borderline groups were regarded as both unnecessary. The J. L. A. classification of the reaction phases was supported. Too subtle a classification should be avoided.

2. *Dr. Namba's proposals and opinions*:

Classification should be based primarily on the lepromin reaction, and the term "stadium" should be used instead of "type." The following scheme results.

Stadium — *Reactional phase*

I. Mitsuda positive:

1. Manifest—tuberculoid
2. Latent { tuberculoid; abortive } ..... *Schub* { Reactional tuberculoid; Neuritic }

II. Mitsuda weakly positive:

1. Manifest ..... Acute infiltration (borderline)
2. Latent { Ante-latens; Post-latens (= secondary neural) }

III. Mitsuda negative:

Lepromatous (so-called).

The indeterminate and borderline groups are both regarded as unnecessary as clinical units.

3. *Dr. Nishiura's proposals and opinions*:

I. Lepromatous type:
1. Macules and plaques;
2. Infiltrations;
3. Papules and nodules.

II. Neural type:
1. Pure neural;
2. Maculoanesthetic.

III. Indeterminate stage.

In this stage there are no clinical varieties. Only histologically can differentation be made between indeterminate, prelepromatous and pretuberculoid forms.

IV. Tuberculoid stage:
1. Minor tuberculoid;
2. Major tuberculoid.

Reactional phases:

I. In the lepromatous type:
1. Erythema nodosum leprosum;
2. Acute lepromatization;
3. Acute infiltration.

II. In the neural type:
1. Neurologic syndromes;
2. Reactional tuberculoid;
3. Acute lepromatization.

III. In the indeterminate stage:
1. Reactional tuberculoid;
2. Acute lepromatization.

IV. In the tuberculoid stage:
1. Tuberculoid reaction;
2. Borderline reaction.

In this classification, "type" means the more stable clinical forms which persist for relatively long times, while "stage" indicates more unstable clinical forms which can change after a short duration into other forms. The tuberculoid macule may be regarded from the immunobiological point of view as a polar type. However, as a rule it exists for a relatively short time and then will transform into the hypochromic maculoanesthetic lesion. Hence, tuberculoid "stage," not "type." The neural type is necessary for the clinical classification. The indeterminate stage is necessary. For example, beginning macules in infants that are neither tuberculoid nor lepromatous would belong to it. Borderline is regarded not as a group, but as a reaction to be seen in the tuberculoid stage.

4. *Dr. Onishi's proposals and opinions*:

I. Lepromatous type.
II. Nonlepromatous type:
1. Tuberculoid-macular subtype;
2. Neural subtype.

The neural class should be preserved, not as a type but as a subtype; it really constitutes the greater part of of the nonlepromatous type. Nearly all such neural cases are Mitsuda-positive. According to Onishi's observations at the Hoshizuka-keiaien leprosarium 6 (13%) among 47 neural cases with slightly positive or negative Mitsuda reactions became lepromatous within an average of 10.3 years, while only 4 (0.8%) among 524 Mitsuda-positive neural cases did so in 12.5 years. Only 6 (3%) among 204 Mitsuda-positive tuberculoid cases became lepromatous within 6.5 years on an average, while 9 (56%) among 16 slightly positive or negative tuberculoid cases changed to lepromatous within 6.1 years. In neural and tuberculoid leprosy, the slightly positive or negative response to the Mitsuda test indicates instability of the disease.

5. *Dr. Saikawa's proposals and opinions* (the figures and percentages referring to the patients in the Nagashima-aiseien leprosarium):

I. Lepromatous type (1,301 = 67.9%):
1. Macules and plaques;
2. Diffuse infiltrations;
3. Papules and nodules.
II. Neural type (429 = 22.4%):
1. Pure neural;
2. Maculoanesthetic.
III. Tuberculoid type (158 = 8.3%):
1. Minor tuberculoid;
2. Major tuberculoid.
IV. Atypical group (27 = 1.4%):
1. Indeterminate cases;
2. Borderline cases;
3. Others.

Reactional phases:
1. Erythema nodosum leprosum;
2. Acute infiltration;
3. *Akuter Schub.*

The neural type is regarded as necessary for the clinical classification. The indeterminate group is necessary for (*a*) the so-called prelepromatous or pretuberculoid cases, and (*b*) lepromin-negative neural cases. The following are believed to correspond to the borderline form: (*a*) tuberculoid cases transformed to lepromatous

after repeated reactions (*akuter Schub*); (*b*) cases in which tuberculoid macules have appeared after absorption of lepromatous lesions; and (*c*) some, but not all, cases of the so-called "acute infiltration" reaction.

6. *Dr. Sato's proposals and opinions*:

I. Lepromatous type:
Nodular;
Plaques;
Macules;
Polyneuritic;
Atypical.

II. Nonlepromatous type:
1. Tuberculoid:
Major;
Minor;
Torpid;
Polyneuritic;
Atypical.
2. Simple inflammatory group:
Simple macules;
Polyneuritic.

III. Stages:
1. Undifferentiated;
2. Dimorphous = borderline.

Reactional phases:
1. Tuberculoid reaction;
2. Lepromatous reaction (= lepromatization);
3. Dimorphous (borderline) reaction;
4. Erythema nodosum leprosum.

As for the neural type, it is desirable to preserve especially the pure neural form. The undifferentiated stage is regarded as a condition in which the immunity and the defense power of tissues are not yet fully developed. The borderline lesion is a dysergic phenomenon which is caused either by the coexistence of allergy and anergy, or by the unbalance of defense power of the tissues.

7. *Dr. Tajiri's proposals and opinions*:[3]

I. Lepromatous type.

II. Nonlepromatous type:
1. Neural;
2. Macular.

III. First intermediate group:
1. Cases which have a tendency to become lepromatous from the beginning of the disease:
(*a*) Simple macular;
(*b*) Cases negative or only slightly positive to the Mitsuda test from the beginning of the disease;
(*c*) Acute infiltration in the early stages of the disease.
2. Cases which transform into lepromatous after long-persisting nonlepromatous stages:
(*a*) Clinically nonlepromatous, Mitsuda-negative;
(*b*) Clinically nonlepromatous, but with lepromas in the nasal cavities or eyes, Mitsuda-positive;
(*c*) *Akuter Schub*.

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[3] This classification scheme was accompanied by a diagram which would be difficult to reproduce here.—EDITOR.

IV. Second intermediate group:
1. Cases which become Mitsuda positive after improvement of lepromas or lepromatous infiltration;
2. Secondary neural cases;
3. Acute infiltration.

Reactional phases:
1. Erythema nodosum leprosum;
2. *Akuter Schub* in macular cases;
3. Acute infiltration in the lepromatous type and the second intermediate group;
4. Acute neuritic syndromes in neural cases;
5. Acute lepromatous infiltration in the lepromatous type.

8. *Dr. Takashima's proposals and opinions*:

I. Lepromatous type.
II. Neural type.
III. Tuberculoid type.

Reactional phases:
1. Erythema nodosum leprosum;
2. Acute infiltration;
3. *Akuter Schub.*

The neural type is necessary and convenient for clinical classification as well as for the management of patients, although a more suitable name is desirable. The indeterminate group is necessary for: (*a*) cases which transform from lepromatous to neural, and (*b*) cases which have clinical features of the neural type but in which small numbers of lepra cells can be found histologically. The borderline group is necessary for (*a*) cases which transform from tuberculoid to lepromatous, and (*b*) undifferentiated and incipient cases.

9. *Dr. Hashimoto's proposals and opinions*:

I. Lepromatous type.
II. Neural type.
III. Tuberculoid type.

The neural type is necessary. The indeterminate and borderline groups are both unnecessary.

10. *Dr. Hayashi's proposals and opinions*:

I. Lepromatous type.
II. Nonlepromatous type:
1. Neural;
2. Macular.

Reactional phases:
1. Lepromatous reactional phase;
2. Nonlepromatous reactional phase:
Neural reactional phase;
Macular reactional phase;
3. Erythema nodosum leprosum.

The neural class should be maintained, but not as a type; it should be a subtype of the nonlepromatous type. The indeterminate group is necessary from the practical point of view. As for the borderline group, its necessity is not yet decided.

11. *Dr. Nojima's proposals and opinions*:

I. Lepromatous (1-3).
II. Macular (1-3).
III. Neural (1-3).

Reactional phases:
1. Erythema nodosum leprosum;

2. Acute infiltration;
3. Acute neuralgia;
4. Acute arthritis;
5. So-called lepra fever;
6. Eye reaction.

The neural type is necessary. The indeterminate and borderline groups are both unnecessary.

12. *Dr. Mitsuda's proposals and opinions*:

I. Lepromatous type.
II. Neural type.
III. Tuberculoid type.

Reactional phases:

1. Erythema nodosum leprosum;
2. Acute infiltration;
3. *Akuter Schub.*

The neural type should be preserved; it is opposite to the lepromatous type as regards resistance against the lepra bacilli. The indeterminate group can be included in one or another of three types. The borderline group is not necessary.

13. *Dr. Miyazaki's proposals and opinions*:

There should be two kinds of classification: a basic one and a practical one. The J. L. A. classification seems almost complete as the practical classification. The neural type should be preserved. The indeterminate and borderline groups are both unnecessary from the practical point of view. As for the reactional phases, the J. L. A. classification is supported.

14. *Dr. Tanimura's proposals and opinions*:

I. Lepromatous type.
II. Tuberculoid type.
III. Neural type.

The neural type should be preserved. As for the indeterminate group, it is well to set it up for some cases. The borderline group is not necessary. The J. L. A. classification of the reactional phases is supported.

V. DISCUSSION

The principal questions involved in the opinions contributed by the several speakers to the symposium refer to: (1) the neural type of the Japanese Leprosy Association classification presented at Madrid; (2) the indeterminate group accepted by the Havana congress; (3) the borderline group adopted by the Madrid congress; and (4) the reactional condition in lepromatous leprosy that some of the Japanese leprologists call "acute infiltration."

Question 1.—Should the neural type be maintained as one of the main types of leprosy? Nishiura, Saikawa, Takashima, Hashimoto, Nojima, Mitsuda, Miyazaki and Tanimura hold for the affirmative. On the other hand Abe, Onishi, Tajiri and Hayashi would acknowledge it not as a type, but as a subdivision of a nonlepromatous type. Anyhow, it is a general opinion among the Japanese leprologists that cases which clinically have nothing other than neurologic syndromes and/or anesthetic, hypochromic macules should be brought all together, as proposed in the J. L. A. classification presented at Madrid. It is a secondary matter whether it

is called a type or a subtype, so long as it is recognized as one of the main clinical units of leprosy.

Question 2.—Is the indeterminate group necessary as a clinical unit of leprosy? One-half of the 14 speakers were against it. Abe, Namba, Onishi, Hashimoto, Nojima and Mitsuda consider it unnecessary, and Miyazaki also would regard it as needless so far as practical classification is concerned. On the other hand, Nishiura, Saikawa, Sato, Takashima, Hayashi and Tanimura think the group necessary for some special cases. Nishiura regards his so-called indeterminate "stage" (not group) as necessary, for example, for early cases in children with macules that are neither tuberculoid nor lepromatous. Saikawa would accept an indeterminate group for some prelepromatous or pretuberculoid cases, as well as for some neural cases with negative lepromin reactions. Takashima considers the indeterminate group as necessary for those cases which transform from lepromatous to neural, and also for neural cases in which small numbers of lepra cells can be found histologically. According to Sato, his "undifferentiated stage" is a condition in which the immunity and defense power of the tissue are not yet fully developed. However, many Japanese leprologists are as yet hesitant to accept wholly the indeterminate group as a clinical unit.

Question 3.—Is the borderline group necessary as a clinical unit of leprosy? No less than 9 of the 14 speakers were against it; only 4 were for it—in one way or another—while 1 (Hayashi) was undecided. Abe, Namba, Onishi, Tajiri, Hashimoto, Nojima, Mitsuda, Miyazaki and Tanimura regard it as not necessary. Saikawa, Sato and Takashima are of the contrary opinion, holding that there are some special cases which should be so classified. According to Saikawa, tuberculoid cases which transform to lepromatous after repeated *akuter Schub,* and cases in which tuberculoid macules appear after absorption of lepromatous lesions —all these cases and also some, but not all, of the cases of so-called acute infiltration seem to correspond to the borderline form of the Madrid classification. Takashima also thinks that the borderline group is necessary for such cases as transform from tuberculoid to lepromatous, and also for some undifferentiated and incipient cases. Sato regards borderline as a dysergic phenomenon caused either by coexistence of allergy and anergy or by unbalance of the defense power of the tissues. Nishiura considers that borderline cases should not constitute a group, but that they represent a reactional condition which can occur in his so-called tuberculoid stage.

Question 4.—About the so-called acute infiltration condition: Among various forms of reactional phases to be seen in the various types, groups, stages or forms of leprosy, the so-called acute infiltration, a reactional syndrome in lepromatous leprosy, has recently become a subject of discussion, and has been studied intensively especially by Tajiri. In the symposium six of the speakers, Namba, Nishiura, Saikawa, Tajiri, Nojima

and Mitsuda, acknowledged it as one of the forms of reactions to be seen in lepromatous leprosy. It is a syndrome consisting of erythematous, more or less infiltrated skin lesions, with fever of 37°-39°C and joint pains, all occurring acutely either in an early phase of lepromatous leprosy, or in the absorption period; it differs from ordinary lepra reaction, or "acute lepromatization." Histologically, sections reveal a tuberculoid structure with coexistence of lepra cells. When it occurs, the Mitsuda reaction tends to change from negative to weakly positive. The condition is regarded as a syndrome which indicates not definitive, but passing, improvement of lepromatous leprosy.

In closing the symposium, Kitamura pointed out that the classification of leprosy has been always influenced by general ideas of medicine of the time when the problem was discussed. Especially in the last decade or two it has become more and more complicated by accepting—from the immunobiological and pathological points of view—various transitional and intermediate forms. On the other hand, there is no doubt that all clinical manifestations of leprosy can differ under various conditions of geography and race. This factor sometimes causes disagreements of opinion among men who, in different regions, have observed and studied their own patients with equal earnestness. It is hoped that this record of the symposium will be of use in drafting a new and more universally acceptable classification, to be presented to the next international congress, scheduled to be held in India in 1958.

VI. SUMMARY

The authors, who were assigned to conduct a symposium on classification of leprosy at the 1955 meeting of the Japanese Leprosy Association, first note the three-type classification that was in vogue in Japan for many years, and then the scheme that was presented at the Madrid congress on behalf of the association.

In preparation for the symposium a questionnaire about preferred criteria and opinions on existing classification schemes was sent to the 305 members of that organization, and the 54 replies received are summarized. Thirty per cent of those who responded would accept the J. L. A. scheme without change, and more than twice as many more would also accept it after some amendment. On the other hand not one of them would accept the Madrid congress classification unconditionally, and only a bare majority would accept it after amendment.

The symposium, held under the chairmanship of the senior author, comprises the personal views of 14 selected workers. The variations are great. In Japan there is a strong and widespread feeling that the old "neural" type should be retained. Certain contributors, however, would simplify the whole matter by dividing all leprosy cases into two classes, lepromatous and nonlepromatous, the latter to be subdivided. The symposium speakers were equally divided for and against an "indeterminate"

group as accepted by the Havana congress, but a considerable majority regarded as unnecessary the "borderline" group adopted by the Madrid congress. Special mention is made in the discussion of the form of reaction in lepromatous leprosy that in Japan is often called "acute infiltration." In closing the symposium Kitamura pointed out that, on the basis of other than the clinical criteria, the classification of leprosy has become increasingly complicated in recent years, and also that regional and racial differences in the disease may explain some of the differences of opinion that exist among serious workers in different parts of the world.

RESUMEN

Los AA., a quienes se les encomendó la tarea de llevar a cabo un certamen sobre la clasificación de la lepra en la reunión de la Asociación Japonesa de la Lepra en 1955, señalan primero la clasificación en tres formas que gozó de boga en el Japón por muchos años y luego el plan presentado en el Congreso de Madrid bajo los auspicios de la Asociación.

En preparación para el certamen, se remitió a los 305 miembros de la organización un cuestionario solicitando las pautas preferidas y opiniones acerca de los actuales planes de clasificación, sumarizándose aquí las 54 contestaciones recibidas. Treinta por ciento de los que contestaron aceptarían sin modificación el plan de la A. J. L., y más del doble de este número también lo aceptarían previa alguna alteración. En cambio, ninguno de ellos aceptaría incondicionalmente la clasificación del Congreso de Madrid y apenas una leve mayoría la aceptaría aun modificada.

El certamen, llevado a cabo bajo la presidencia del primero de los AA., comprende las opiniones personales de 14 técnicos escogidos. Reinan muchas variaciones. En el Japón impera la idea de que debe retenerse la antigua forma "neural" (nerviosa). No obstante, ciertos participantes simplificarían todo el asunto, dividiendo todos los casos de lepra en dos clases: lepromatosos y no lepromatosos, subdividiendo los últimos. Los concursistas se dividieron por igual entre en pro y en contra del grupo "indeterminado" aceptado por el Congreso de La Habana, pero una mayoría considerable declaró innecesario el grupo "marginal" adoptado por el Congreso de Madrid. En la discusión, se hace mención especial de la forma de reacción observada en la lepra lepromatosa y que en el Japón llaman a menudo "infiltración aguda." Al clausurar el certamen, Kitamura apuntó que, a base de pautas distintas de las clínicas, la clasificación de la lepra se ha vuelto cada vez más complicada en años recientes, y además que diferencias regionales y étnicas en la dolencia acaso expliquen algunas de la diferencias de opinión que existen entre técnicos concienzudos de diversas partes del mundo.