CORRESPONDENCE

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ATYPICAL MACULAR LESIONS IN NIGERIA

TO THE EDITOR:

In reply to your inquiry about my personal experience of atypical macular lesions in this region, let me refer to what I wrote on the subject in 1946, in the second part of an article on allergy in leprosy [*Leprosy Review* **17** (1946) 75] which was deemed of sufficient interest to be reprinted in THE JOURNAL [**16** (1948) 62]. That article was written at our peak period, when I had had clinical experience of many thousands of cases of what I called the "macular series," and it was an attempt to make some sense of them. At that time I had had very little experience with leprosy in other regions, and did not realize that there was anything unusual here. All that was certain was that the standard classification adopted by the Cairo congress (1938) did not adequately cover clinical leprosy as we see it here.

I might have said something about the matter at the Havana congress (1948), but there had been no opportunity to make adequate studies with lepromin and histopathology, which seemed necessary in view of apparent differences between my observations and findings in other places. Furthermore, shortly after Ryrie's visit in 1946, Dharmendra came here and said that Nigerian leprosy was closely similar to what occurred in South India, the leprosy of a hot, moist climate with no cold season. Lowe, whose previous experience had also been in India, was of the same opinion when he came here in 1947, but later—especially after he began to do lepromin work himself—he found difficulty, as we all did, in classifying patients on clinical grounds alone.

What I wrote in 1946 still holds good. We see here every gradation in the macular series intermediate between tuberculoid and lepromatous; and the clinical findings, the results of the lepromin test, and the histopathology all fit together quite coherently. The basic pathology is an infiltration of macrophage type, usually quite dense.

At the lepromatous end of the intermediate series, an infiltration of typically lepromatous type may be encountered superficially in the corium, but more deeply the dense macrophage infiltration dominates, especially in relation to nerves and sweat glands. Infiltration of nerves is usual, and may be marked, much more so than would be expected in

an ordinary lepromatous lesion. In cases within the intermediate range of the series, a dense macrophage infiltration is the characteristic feature. If it is confined to the superficial layers, the case comes within the indeterminate group. When more of the corium is involved, the macule will be raised and infiltrated. Approaching the tuberculoid end of the intermediate series, the increasing tendency to localization observed clinically in macules has its counterpart histologically in increased focalization and the appearance of groups of epithelioid cells here and there within the macrophage infiltration, often first in the deeper layers of the corium. Clinically such cases may be very close to tuberculoid, but apart from the histological picture their true character is always revealed by the lepromin test, for the reaction to integral lepromin is only weakly positive, and that to Lowe's antigen is too small to be read.

If all this group can be included in classification under "borderline" or "dimorphous," we need not bother much more about them. It must however be admitted that the description of these terms as adopted by the Madrid Congress and continued by the Tokyo Congress does not cover these cases. Furthermore, neither term is a fair descriptive designation of the broad spectrum of clinical forms which have in point of fact a distinctive histology, and clinical and immunological features peculiar to themselves. I would like to see a different term applied to them, one that does not ignore their essentially unstable, dynamic character. This would be very helpful in Nigeria, where these clinical forms constitute an important group among our patients.

(Lately of) Leprosy Service Research Unit T. Frank Davey, M.D.
Usuakoli, Eastern Nigeria