

TO THE EDITOR:

ATYPICAL MACULAR LESIONS OF LEPROSY

The subject of atypical features of leprosy in Africa, specifically atypical macular cases, is brought forward by the interesting paper of S. G. Browne in a recent issue of *THE JOURNAL* [27 (1959) 103-109].

At the outset of his paper, Browne wisely states that the clinical appearances and evolution of atypical macules vary from country to country, as do also their relative frequency and their epidemiologic importance. I agree with this, and would add that the picture may vary from region to region in the same general area. In my own experience in East Africa the frequency of these intermediate macular forms of leprosy is very much less, and also their epidemiologic importance, than seems to be the case in the Belgian Congo and Nigeria—of which latter region Davey has written.

In East Africa leprosy is more clear-cut. There we have the relatively stable depigmented anesthetic macule, which on the whole tends toward the tuberculoid side of the fence; while there is an unexciting proportion of cases of the more labile macules, which in their evolution

tend toward the lepromatous side. Histology and lepromin testing confirm this, as well as the bacteriologic findings. These labile macules—to which the term “indeterminate” adopted by the Havana congress seems particularly applicable—may be quite flat, but they may evolve to elevation, succulence, and symmetrical location on the body, and become increasingly bacilliferous; but the whole evolution seems to me much less urgent, more “slow motion,” than in the other African countries mentioned.

The causes of this variation of macular leprosy in different regions are no doubt multiple and complex, but I note that Browne gives more than a hint that he thinks that climatic influences are important. In the tropical rain forest of the Belgian Congo the fairly high temperatures and the sustained high relative humidity lead to great activity of the skin and its appendages; and he also suggests that there is a tendency of the deeply-depigmented skin of the natives there to over-react to stimuli. I think the two lines of this hypothesis, namely, climatic influences and the pigmentary system of the skin, should be considered and studied seriously.

Next, I think it is necessary to come to a decision as to what we mean in leprosy by the word “macule.” It would help us through the jungle of terms which have been applied to various intermediate forms of leprosy if, as has frequently been proposed, “macule” should be used only in the strict dermatologic sense of “a spot.” It can be visually delineated from the surrounding skin, but has no elevation—central, peripheral, or over-all—above the general skin level. In the course of later evolution such a pure, or “simple,” macule may develop such changes as elevation, beading, and the like, but then it should be given a different name appropriate to the nature and extent of the change.

I must confess that this idea appeals to me, as there is more to be gained by the careful choice of terms, even if they understate but are accurate as far as they go, than by inventing portmanteau names which are premature to our knowledge and liable to cause confusion. Take, for example, “dimorphous macule.” I read that term, at its simplest and strictest in Churchillian English, as “two-shaped spot”—which is unsatisfactory. On the other hand the term “indeterminate,” in accepted use for more than a decade, is not so bad. It conveys the sense of a lesion which has the potentiality of evolving toward either the benign form on the one hand or the malign form on the other hand.

(It should be noted that the term “borderline” is not applicable in this field of macular leprosy. In both its original application and its adoption in formal classification it signifies a very different class of cases, as is clearly evident from the brief but succinct descriptions adopted by the First WHO Expert Committee on Leprosy (1952) and the Madrid Congress (1953). It is the form for which Rotberg [*Rev. brasileira Leprol.* **21** (1953) 13-15] suggested the term “bipolar,” while

he suggested "infrapolar" for the indeterminate macular class of cases.)

In the future study of the intermediate forms of macular leprosy I hope that, in addition to caution in the use of terms, we shall make fuller use of the clinical approach, without neglecting the essential studies of histology, immunology, and bacteriology. Extended clinical observation cannot be replaced by histology but must be supplemented by it, and a clinical assessment of the relative stability or lability of the lesions in question by prolonged observation of the cases is a highly practical matter. We have to keep in mind also the study of the modifying effect of therapy, and those of the reactive phenomena.

I do not think that as yet we have enough information to give a systematized explanation of these intermediate forms of leprosy. We should get on with the patient study and correlation of facts in all countries until such time as a synthesis of the new information can be attempted. In my view, the formal classification of leprosy developed at Havana and Madrid constitutes a definite and valuable advance, and should be left alone until such time as we have very solid reasons for modifying it, based on more correlated extensive study over a long period. In the meantime we might desist from throwing premature schemes at each other and preaching them with the fervor of Peter the Hermit, and get down to the acquisition of further knowledge—welcoming in that sense such thoughtful papers embodying the results of experience as the article by Browne referred to.

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