CORRESPONDENCE

This department is provided for the publication of informal communications which are of interest because they are informative or stimulating, and for the discussion of controversial matters.

CLASSIFICATIONS

To the Editor:

I have been very interested in letters from you and Dr. Gay Prieto on the subject of classification. I would welcome an opportunity to talk about one or two matters to help clarify my own views. I share in the confusion to which you have both referred.

For my own part I should like to see: (1) a simple classification divided into two groups, (*a*) lepromatous, and (*b*) all other cases, based on clinical signs, for use by general-duty medical officers. I do not think, for the practical purposes I have in mind, that names would matter very much. Such a distinction in records and annual returns would help considerably to trace the general progress in a mass campaign.

(2) A systematic classification based on clinical signs, coupled with the results of bacteriological, immunological and histological examinations, for use in leprosaria and hospitals with adequate laboratory facilities.

Nonspecialist officers are usually unable to attempt anything more involved than (1). If exceptionally they do, many of their answers are wrong. I am, of course, referring to Africa, where a large part of the burden of medical care and public health administration is carried by doctors from overseas. They move from one district to another, each with its different problems. They may spend only part of their service in the leprosy areas, and that part may not be continuous. In these circumstances, faced with diseases which to them are of greater interest or which have a simpler terminology, they take the line of least resistance and leave leprosy to the one or two who specialize. Even where there are adequate laboratory facilities, clinical diagnosis has sometimes to be adjusted after the other examinations have been made.

I think every effort should be made to stimulate the collection of material evidence which will enable a more satisfactory (*b*) classification to be produced, one which will be universally understood even if the local scene does not include every feature. I am not in favor of frequent changes either in the system or its definitions because, in the circumstances I mentioned, confusion is increased and interest correspondingly diminished. This does not deny the advisability of reexamining one's experiences in appropriate circles; this should naturally be encouraged. I am sure, however, that the attempt to encourage the control of leprosy within the framework of the general health services will be promoted more easily if what is debatable is restricted to those who have sufficient experience to understand the problem. The

officers in those services should not be diverted from the basic facts that are essential for diagnosis, treatment and control.

Personally I associate borderline leprosy with the material included in the talk at Madrid by Molesworth on "The Natural Course of Untreated Leprosy in Malaya." This was illustrated by pictures of succulent lesions which, in some of the transparencies, were almost cherry-like in appearance—lesions which had developed after a severe reaction or a number of reactions in a tuberculoid patient. When "dimorphous" was linked with borderline in the light of the Madrid definition, I took it that the terms were interchangeable; I did not understand that it represented an exaggerated variety of phases through which the majority of cases passed. Any such alteration would pass the diagnosis back completely to the laboratory.

Nevertheless, we see untreated cases with succulent lesions that are bacteriologically negative; others have raised lesions with a tuberculoid histology but a clear subepidermal zone and a doubtful Mitsuda reaction. The indeterminate group ought to be an understandable entity. I have assumed the histology is neither one polar type nor the other, being preliminary to the development of one or other of the polar types. I am confused when I read that the histology can be dimorphous. Moreover, when the type progresses to more than a few indeterminate lesions there does seem to be reason for placing it in a class by itself. In this sense I appreciate the distinction of a maculoanesthetic group.

There is another element which may affect the issue in some patients, namely, the impact of treatment, especially in mass campaigns. This can apply to both the infecting agent and the individual response. The recent introduction of the term "reversal reaction" for what may be a new reactionary phase is a case in point.

There are other variations that need clarification, and I think the answer by the Tokyo congress suggesting more investigation is probably the right one.

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