CORRESPONDENCE

This department is provided for the publication of informal communications which are of interest, whether because they are informative or are suggestive and stimulating; to serve as an open forum for discussions of matters of interest; and for questions and answers by members of the editorial staff and others.

TUBERCULOID LEPROSY AND CLASSIFICATION

To the EDITOR:

The article by Wade on tuberculoid leprosy as seen in South Africa, published in the first number of the current volume of the JOURNAL, is of special interest to us who are working in this region. The reasons for this interest are such that it may be worth while to bring them to the attention of workers elsewhere.

We here see many cases that are of the kind described, and in a recent paper I remarked upon the difficulty of distinguishing between certain Cl and Nl cases by the naked eye appearance alone. I also referred to the late Dr. Slack's frequent remark that he seldom found anesthesia in macules appearing on the trunk of cases which he diagnosed as pure Nl.[1]

Having recently been on long leave I have had an opportunity to compare the practices of two medical officers in classifying cases in South Africa. One of them, Dr. A, classified as Cl nearly all the earliest cases in a certain convalescent village, and it became evident that in the long run the Cl group would preponderate to a much greater extent than previously. It appeared that Dr. B called a case Nl if it had no raised-edged lesions, whether there was anesthesia or not, but that Dr. A held that if there were neither anesthesia nor symmetry (bilateral) the case was a C type. It has been my own opinion, from the subsequent histories of his cases, that the practice of Dr. B was sound and that his Nl cases were of that type. The arrests among them were three or four times as numerous as among his C cases.

[1] The article referred to appears elsewhere in the present number of the JOURNAL.—EDITOR.

One physician of my acquaintance contends that all skin macules should be called cutaneous leprosy because the lesions were in the skin! But when at my suggestion he made an examination for bacilli in a case with large circinate macules with angry-looking raised edges and found none, he suggested that we write to the JOURNAL for a discussion of the differentiation between the macules of C and N cases. From the plates in the article referred to it would seem that that is the answer to the question in mind. I think it highly probable that it is these tuberculoid cases that make the difference between the views of Drs. A and B with respect to classification. However, it is much to be desired that an understanding be reached as to whether or not the pure tuberculoid cases should be classed as pure Ns.

P. D. STRACHAN, M.D.,
Medical Superintendent.

Botsabelo Basutoland Asylum
Maseru, South Africa.

Comment by Dr. H. W. Wade, Culion, P. I.:

The question raised here is, in my opinion, an important one, and is the subject of a paper now in press, to appear in the next issue of the JOURNAL. Though one would not wish to anticipate it fully, it may be pointed out that many who deal with leprosy seem to be under the impression that all grossly infiltrated, raised lesions, whether they be marginate macules or solid plaques, are to be considered of the "cutaneous" type, regardless of their histological structure or bacterial content; that an astonishingly large amount of diagnostic work in leprosy is based on gross findings alone, without aid of or check by the bacteriological examination; and that at the present stage of our understanding of the matter the clinically recognizable tuberculoid lesions are infiltrated but show no bacilli—or if any so few that they differ strikingly from the usual lepromatous lesion of cutaneous leprosy. Until there is a general understanding in this matter and a change in attitude toward the bacteriological examination—which is often looked upon as a procedure to be resorted to only in exceptional cases rather than as an indispensable part of the clinical examination—there is bound to be more or less confusion in classification, and consequently in conclusions on questions such as the clinical picture of leprosy as a whole and the effect of treatment.

As a preliminary step it is to be desired that there be agreement concerning the significance of the term "cutaneous" as used in the classification of leprosy. One does not have to look far in medical literature for differences between the common or general use and a precise or special use of a single term. For example, "bacillus" in vulgar usage applies to any of the rod-shaped bacteria, but used precisely it designates only one particular group of them. "Cuta-

neous'' as the name of a type of leprosy has always signified a certain symptom-complex, contrasting with that of the other, the ''neural'' type, but there has never been any intention that all cases with changes in the skin (i.e., ''cutaneous'' changes in the general sense) should be considered of the cutaneous type, any more than that all cases with nerve changes should be classed as of the neural type. However, there has always been some misunderstanding on this score, for which reason some leprologists have deprecated or avoided cutaneous as a type-name. The matter was argued at length at the Memorial round-table conference in 1931 before that conference decided to retain the term, but it was believed that the definitions adopted would obviate further confusion in the matter.

As for the question of which of the two types as set up by the Memorial Conference embraces the typical unmixed tuberculoid cases, one must depend less on legalistic minutae of definitions that are subject to revision, or on gross clinical appearances that may be misleading, than on basic findings and the experience of those who have dealt with such cases over long periods of years. Both the absence (or rarity) of bacilli and the nature of the tissue reaction in the tuberculoid lesion bespeak a degree of resistance to the infection that is characteristic of the neural rather than the cutaneous type, and the typical clinical history would seem to bear this out. In Japan, South Africa, and it is understood in India, such cases are classed as neural, and I have personally come to the conclusion that this is correct. This is not to say that all cases with tuberculoid lesions are to be so classed, for there are ''mixed'' cases with both tuberculoid and lepromatous lesions, the latter of which would of course take precedence, but that does not affect the question of the unmixed tuberculoid case.