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.

PRIORITY RE ORAL DDS THERAPY

To the Editor:

May I refer to the letter of Professor Jacques Trefouel under the above heading in The Journal **30** (1962) 202-203 (1)?

Priority in publication of the results of oral treatment of leprosy with dapsone [DDS] should, as Trefouel claims, be accorded to Floch.

An interesting footnote appears on p. 656 of an article by Lowe and Davey (2). It reads as follows:

"It now appears that the oral use of D.A.D.P.S. in leprosy originated in 1948 in three different centres, each centre apparently being ignorant of the work of the others. The three centres were, in Nigeria (Lowe and Smith), in Brazil (de Souza Lima), and in French Guiana (Floch and Destombes). All three centres in 1949 issued and published accounts of their work. All have used roughly the same daily dose, 100 mg. to 300 mg. All find it safe and clinically effective."

Priority in the oral use of *low-dose* dapsone, although not in the publication of results, should go to Lowe, for it was on October 4, 1948, that his first group of patients began their treatment. The results were transmitted by Lowe to BELRA in his 1948 report. This report, of course, does not constitute "publication" in the accepted sense.

In the early months of 1949, I gave dapsone orally in low doses to a small group of patients at the Yalisombo Leprosarium, Belgian Congo, but here again no "publication" of the results can be claimed.

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2. Lowe, J. and Davey, T. F. Four years' experience of sulphone treatment of leprosy. Trans. Roy. Soc. Trop. Med. & Hyg. **44** (1951) 635-662.

To the Editor:

I was interested in the letter from Professor Jacques Trefouel published in April-June 1962 issue of The Journal (1). I am glad to be put right on the priority of the use of diaminodiphenyl sulfone by mouth. I

was well aware of the work of Trefouel and Buttle on the antistreptococcal activity of DDS in mice, but regret that I missed the publication of the early work of Floch and Destombes.

Much water has flowed under the bridge since these early days, and there is not much point in going back over past ground. I think it is true that many of us have had to revise our early opinions, and one could not agree more with Spencer Reed [2] when he says, of orthopedic and plastic surgery, that "It is the neglect of the use of modern drugs that alone has made this advance possible, giving the surgeons much fodder."

On the other hand, it is not always realized that the injudicious use of modern drugs in the reactional tuberculoid case (Leiker's low-resistant tuberculoid), and particularly in the reactional borderline case, may cause greater damage than withholding them, and it is the task of the physician to judge when to withhold them. On looking back at the letter by Reed referred to, I note that he had used as low a dose as 50 mgm. a week in "semi-advanced" lepromatous cases with favorable results. Certainly, all the experience which we have had during the past ten or fifteen years indicates that low dosages of DDS are effective, and that the maximum dose should never be more than 400 mgm. a week, and for many cases much smaller doses are indicated.

There is one point in Trefouel's letter of which note may be made. He states that I had "declined to admit that the activity of [Sulphetrone] was due to the liberation of the parent sulfone" as if he disagreed although he did not say so. Much work during the past ten years, particularly that of Bushby and his associates, indicates that when a 50 per cent solution of aqueous Sulphetrone is injected into the body it is not broken down to DDS, but is transformed to a monosubstituted sulfone. One of the amino-acid groups is freed and a substance called semisulphetrone is liberated, and this is an active principle against *M. leprae.*

Two facts are clearly established: (1) the efficacy of DDS in small doses in the treatment of leprosy, and (2) the necessity to use the less potent antileprosy drugs in order to tide over the difficult complications which arise from time to time in the treatment of the more active lepromatous and the reactional tuberculoid and borderline cases in which the damage is due to the tissue response rather than the bacilli. The hypersensitivity reactions in these cases may have to be damped down by the means of adequate doses of the corticosteroids.

To one who has been in leprosy work for close to 40 years, the progress that has been made is a matter for rejoicing. There is at last hope that we are beginning to see the conquest of this ancient mycobacterial invader. Nevertheless, let us keep our balance so that the whole picture of leprosy may be brought into focus.

It is regrettable that so few internists or physicians are willing to study leprosy. It is the surgeon who has made the greatest contribution to leprosy during the past decade, for he has appreciated the value of reconstructive surgery in this disease. The field now has largely been turned over to the surgeon and paramedical worker. By and large, the physician (internist) has not yet fully appreciated the value of the study of leprosy for the solution of many basic fundamental research problems in that disease.

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