CORRESPONDENCE

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LOW-RESISTANT TUBERCULOID LEPROSY

To the Editor:

In my copy of the October-December 1964 issue of the International Journal of Leprosy I read with great interest Dr. Leiker's article on "Low-resistant tuberculoid leprosy." I am afraid, though, that while he makes a plea for not adding to the confusion already in existence with regard to the classification of leprosy, he has succeeded in making confusion more confounded! If Dr. Leiker would kindly refer to the chapter on "Classification" in the 2nd edition of "Leprosy in Theory and Practice" he will find what he has referred to as low-resistant tuberculoid leprosy described in two sections of that chapter, namely under what I have termed, perhaps incorrectly, low-resistant tuberculoid leprosy, better named disseminated tuberculoid leprosy, and in the paragraphs dealing with maculo-anesthetic (pre-tuberculoid) leprosy. I look upon both these clinical manifestations as subtypes of tuberculoid leprosy, and, as far as I know, they remain true to type. The maculo-anesthetic lesion, if it becomes active, passes in all probability to disseminated tuberculoid subtype of tuberculoid leprosy. The term reactional tuberculoid leprosy, which I used in the first edition of my book, is inaccurate, for that term should be applied only to tuberculoid lesions in the reactional phase.

My principal objection to Dr. Leiker's use of "low-resistant" tuberculoid leprosy is that it is *not* low-resistant, for, in terms of resistance, these lesions show a strongly positive lepromin reaction, sometimes so strongly positive that the lepromin reaction ulcerates; furthermore, the clinical features are similar to those of established tuberculoid leprosy except that the lesions are multiple and, as a rule, there are satellites or outcrops of lesions, but, apart from this, histologically, clinically, and immunologically the lesions appear to be the same.

I firmly agree with Leiker when he says that "low-resistant type of tuberculoid leprosy does not transform to lepromatous leprosy." In other words, the lesions are tissue-stable. We have followed one such case over a period of 6 years and every time the patient showed a reactional phase the lesions did not depart clinically, histologically or immunologically from the standard picture of this variety of tuberculoid leprosy. I admit that the phrase, originally used in the first edition of my textbook, "reactional tuberculoid leprosy" is not a correct description of these lesions. Neither is Leiker's alternative suggestion of "low-resistant tuberculoid." To my way of thinking this "low-resistant tuberculoid" can be divided into two clinical subtypes, one, the early macular phase referred to by the Indian workers

as maculo-anesthetic leprosy, and the other, made up of infiltrative lesions, as disseminated tuberculoid leprosy, for I consider that this is exactly what these lesions are.

In regard to the terms used in the classification of leprosy, Dr. Leiker is not quite correct when he says, "Apart from the disadvantage of introducing new designations, such as 'dimorphous,' which have not met with general agreement, etc." may I remind Dr. Leiker that "dimorphous" is used as an alternative term in the report of the classification committees of the Sixth International Congress of Leprology at Madrid and the Eighth at Rio de Janeiro. Furthermore, Dr. Khanolkar and I coined this term as an accurate description of a group between tuberculoid and lepromatous leprosy; previous to this I had referred to these lesions as intermediate, which, if there is going to be disagreement with regard to the term dimorphous, I consider a very suitable alternative designation. I used this term as far back as 1938 when an article was published in the INTERNATIONAL JOURNAL OF LEPROSY on this subject. May I suggest to Dr. Leiker that the term "borderline" is extremely unsatisfactory? Dr. Leiker in his description of low-resistant tuberculoid leprosy keeps on talking about the spectrum of leprosy, and I would like to know what "borderline" means in regard to the spectral conception of leprosy? I had the privilege of hearing Dr. Wade at the Conference of the Indian Association of Leprologists and his "borderline leprosy," as he describes it, is correct, but he is describing lesions which I would classify as dimorphous or intermediate leprosy well toward the lepromatous end of the spectrum. In other words, what Dr. Wade is describing can be truly said to be "borderline," for these lesions seem to be right on the border between lepromatous leprosy and dimorphous lepromatous leprosy, or, to put it in another way, these lesions are in the dimorphous zone, but the bacillary element is very much in the ascendancy and they show minimal tissue response.

Let us not get into the wrangle of classification, for, after all, what do names matter so long as the terms we use are adequately described? I would, however, congratulate Dr. Leiker on his excellent presentation of what he has termed "low-resistant tuberculoid leprosy."

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