we would have done so. Our study, however, was based on hundreds of cases and the total picture differed from granuloma annulare so much that we had to choose between a major revision of the well-established concept of a long and well-known disease or calling the condition a new disease. We preferred the latter. The fact that many cases seen in the past decades by many competent doctors were not diagnosed as granuloma annulare at least shows that the condition does not correspond with the textbook descriptions of this disease.

We fully agree with Dr. Jouguieres’ remark that cases of granuloma annulare in adults with the same location as our cases have been frequently published, but that is not the point. The peculiarity of granuloma multifforme is that all patients are adults, mostly older adults and particularly old people. Not a single case was seen in children.

Also, it is not significant that in most patients the lesions are at the upper parts of the body; it is peculiar that no lesions were found on hands.

As a rule itching is absent or slight in granuloma annulare. In our patients it was always present and, as our patients normally are not much worried about a slight itch, it must have been rather marked, because most patients complained about the itching.

Granuloma annulare usually disappears after some weeks or some months, occasionally after more than a year. Granuloma multiforme is on the average much more chronic and histories of many years’ duration are common.

Granuloma annulare, as the name indicates, usually presents annular lesions. Admittedly, other types of lesions do occur more often than most textbooks suggest, but they are, nevertheless, not as frequent as in granuloma multiforme.

As we intended to describe the histology in greater detail in a nonleprosy periodical, the present description is not comprehensive. Unfortunately the micrographs were not printed. Here again, we have seen sections that were very difficult or even impossible to differentiate from granuloma annulare, but the overall picture of hundreds of sections differs substantially. The collagenous degeneration in granuloma multifforme is predominantly found in the center of intense granulomatous infiltration, whereas in granuloma annulare the extension and intensity of the degeneration are on the average much greater and the granulomatous infiltration is less. In granuloma multifforme particularly the upper part of the dermis is affected, whereas in most cases of granuloma annulare the affected parts are found deeper in the dermis.

With regard to the radial arrangement of fibroblasts and histiocytes, we ourselves have failed to find this in a large proportion of sections of granuloma annulare, but this sign was virtually absent in sections of granuloma multiforme. Giant cells may be found in granuloma annulare; they are usually scanty and seldom abundant. In granuloma multiforme usually large numbers are seen.

In our opinion the differences are sufficiently great to speak of a new disease; at least until more similarities between the two diseases are established and the etiology is known. We think that it is quite possible that the two conditions are closely related and that even if the causative agent is different, the pathologic mechanism may be basically the same. We do not entirely exclude the possibility that the two conditions have the same etiology. If that is true granuloma multiforme would become a more appropriate name for granuloma annulare.

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Low-resistant Tuberculous Leprosy

Disseminated tuberculous is a descriptive designation meaning tuberculous leprosy with multiple lesions. Low-resistant tuberculous leprosy is a significant designation
meaning that, although the patient is tuberculous, his resistance is lower (not low!) as compared with other high resistant tuberculous patients. Lower resistance means that the chances of dissemination are greater or that dissemination already has occurred, and that special caution in treatment and prognosis is needed in view of nerve damage. Most important is the fact that the degree of resistance often can be deduced from the clinical signs of the lesions.

I agree with Dr. Cochran that patients with disseminated tuberculoid lesions may show a strongly positive lepromin reaction and that they have a high resistance. Therefore not all disseminated tuberculoid patients are low-resistant tuberculoid patients. Also, not all low-resistant tuberculoid patients present disseminated lesions. Therefore I object to the designation disseminated tuberculoid.

It certainly happens in patients with a high resistance that bacilli escape from a lesion and that they produce more lesions elsewhere. Such a patient has become disseminated tuberculoid. But the new lesions will show the typical features of a high resistance and therefore the patient is not a low-resistant tuberculoid case. Such patients show a strongly positive lepromin reaction.

In my experience, however, a large proportion of the tuberculoid patients with large, widely disseminated lesions, particularly when the lesions have appeared in more than one crop, do not present a strongly positive lepromin reaction. The reaction is definitely positive, but not strongly so. The patients present lesions that show the lower resistance.

The matter becomes intelligible when one considers that patients with high resistance are capable of destroying the bacilli more rapidly. The bacilli have less time to multiply and the chances of escape from the lesions are smaller than in patients with a lower resistance.

In patients with a single lesion one cannot speak of disseminated tuberculoid, but one may be able to diagnose low-resistant tuberculoid leprosy. This is possible when the lesions (1) show incomplete and delayed central healing, resulting in a broad papular edge, (2) when the papules are very minute, indicating only slight tissue response to the presence of bacilli; and (3) when satellite lesions are seen indicating that the greater number of bacilli and the longer duration of their presence have increased the chance of escape. In addition, there may be other signs, such as little hypoplasia, little loss of hair, and little loss of perspiration indicating that there is no gross infiltration around the appendages of the skin, due to comparatively little tissue reactivity. "Flaring edges" may complete the picture. These features are danger signs.

With regard to Dr. Cochran's principal objection, low-resistant tuberculoid does not mean low-resistant leprosy, but the designation "low-resistant" is used in conjunction with tuberculoid. It separates a group of tuberculoid patients with a higher resistance from a group of tuberculoid patients with a lower (not a low) resistance. When this principle is recognized, I shall welcome a more appropriate designation.

I am aware of the fact that the term dimorphous has received official recognition as an alternative for borderline, but is the agreement really general? Personally I have little objection to the use. I would prefer intermediate, if this term were not easily mixed up with indeterminate.

Dr. Cochran's concept of dimorphous is much wider than borderline as described by Wade. If I have to choose between a limited borderline group and a wider dimorphous concept I prefer the latter.

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