Frequency of Borderline Leprosy

To the Editor:

In his recent paper entitled "Contribution to the study of borderline and indeterminate leprosy" (The Journal **33** (1965) 813-828) Azulay refers to the frequency of borderline leprosy, stating: "As regards the frequency of borderline leprosy in comparison with the other forms of leprosy, the following data have been placed on record: (a) Convit, Sisirucá and Lapenta, 3.2 per cent; (b) Browne, 3.2 per cent; (c) Alonso and Azulay, 6.4 per cent; (d) Antonio Carlos Pereira, 1.3 per cent; (e) Paulo Rath de Souza, 0.5 per cent; and Nelson de Souza Campos, 1.3 per cent." Later he added: "The highest of all these figures is that of Alonso and Azulay (6.4%), which is justified by the interest these authors have taken in the subject."

It is unfortunate that Dr. Azulay, Chairman of the Panel on Indeterminate and Borderline Leprosy at the Congress in Rio de Janeiro in 1963, who surely had read the article on this theme which we sent in advance (this was published as No. 38 in the abstracts of papers [see E. D. L. Jon-

quières, Clinical, histological and immunological aspects of dimorphous leprosy, THE JOURNAL **31** (1963) 533-534] distributed before the beginning of the sessions), has not considered it of interest to register the 8 per cent that we noted in the Central Dispensary of Dermatology (Buenos Aires) for the dimorphous group, which, without doubt, represents the highest figure published up to date.

We agree with Dr. Azulay in his statement: "The possibility that a medical practitioner will be right in his classification of leprosy cases on the basis of dermatoneurologic symptoms is higher than 90 per cent." We would like to add our belief that with some practice the dimorphous leprosy under consideration can be diagnosed in an increased number of cases "as long as one observes and follows up the cases dynamically. The adoption of a static, or purely histopathological criterion is what has given rise to the Byzantine discussions that revolve about this form of leprosy," as I said in the paper I presented at the VIIIth International Congress of Leprology.

In addition I wish to emphasize that due importance does not seem to have been given to the fact that I have repeatedly expressed, in various published works, the fact that in reactional states (the real "borderline" picture in my conception, as long as the term "dimorphous" means for me quiescent states, including macular varieties) *no erythema nodosum is seen,* even though they are at times accompanied by dissemination of the lesions, particularly on the face, back of the neck, and elsewhere.

Otherwise Dr. Azulay's article is excellent, and in large measure is in agreement with our experience. Differing from what other authors have indicated, we have called attention to the rare neural repercussion in dimorphous leprosy (*Leprología* **8** (1963) 48-49). Dr. Azulay stresses the same fact in his casuistic when he states: "Nerve involvement: this is much less than in L cases, not only in intensity but also in frequency."

It is interesting, in addition, to note the 16.6 per cent of cases of Azulay and Alonso that became lepromatous in spite of treatment. In our statistics on 115 dimorphous cases we have noted 19 per cent of lepromatizations in patients treated with sulfones, including four cases diagnosed by other colleagues as reactional tuberculoid and by us as dimorphous tuberculoid.

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