These figures illustrate that Group A showed a marked reduction on B.663 alone, which was maintained on B.663 plus sulfone. Group B showed a slight deterioration on B.663 and sulfone, probably consistent with the fluctuating nature of the disease, but a marked improvement followed when the sulfone was stopped. Group C, which we are told was a "more representative group," showed some 30 per cent reduction in ACTH requirements when B.663 was added to the sulfone regime. When sulfone was stopped the ACTH requirements were reduced by 82 per cent.

DISCUSSION OF THE RESULTS

Improvement occurred in all groups during the period of treatment when sulfone was stopped. This would suggest that the administration of sulfone is in some way related to the continuing presence of ENL, since a similar result was obtained whether sulfone was stopped at month 3 or at month 10. This would seem to invalidate the author's statement that "this study should also disprove the much repeated misconception concerning the sulfones in ENL."

In Group C the addition of B.663 to sulfone did, in fact, diminish the ACTH requirements, and this might well represent an anti-inflammatory action of B.663. The fact that this did not occur in Group B may be related to the fact that Group B was a less representative group than Group C. There is, however, conclusive evidence from the figures presented that B.663 administration does not produce a deterioration in ENL. There is possible evidence that it has an anti-inflammatory effect. This could be determined by comparing two groups of patients, one treated with B.663 alone and the other going without treatment for similar lengths of time and at the same period of the evolution of the disease (if this was not detrimental to any patient). There appears to be no justification for the categorical statement that "(our findings) show conclusively that B.663... has no anti-inflammatory effect in ENL."

The ability to demonstrate whether B.663 has an anti-inflammatory action or not would have been greatly helped if a less rigid attitude to dosage had been adopted. The author's figures show that "steroid" therapy needs to be increased or decreased according to the severity of the patient's disease and its stage of evolution, and it seems that a similar attitude should have been taken toward B.663.

The author did not consider that higher dosage would give more satisfactory results, but gives no indication that he had ever used higher doses, and previous publications (1, 2) on this subject strongly support the view that higher doses are needed to suppress ENL in some cases. We have, however, as yet unpublished, evidence to support this view.

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interesting observation shows the difficulties that can sometimes be experienced in separating out certain cases of borderline leprosy from the lepromatous type. If exacerbations of ENL can be produced in patients with borderline leprosy, it may be believed that ENL is more truly associated with the presence of bacilli in quantity than with the strictly limited class of lepromatous types. In order to define the subject more broadly we would like to reproduce here the paragraph "ENL in borderline leprosy" published in March 1965 in a study devoted wholly to ENL (5) (translation by the Editor):

"ENL never appears in cases of leprosy primarily nonbacilliferous, notably in tuberculoid leprosy. In the sense of the majority, it is the lot of the lepromatous type; this is true, but not absolutely so. We have seen this eruption in certain bacilliferous, non-lepromatous forms, and especially in borderline disease."

"As early as 1937, before the recognition of intermediate states, F. Reiss (5) called attention to the cutaneous histology in a young Chinese patient suffering from ENL of giant and epithelioid cell granulomatosus type, with some bacilli. Later, at the Madrid Congress (1953), H. W. Wade (1) reported the same verification in two patients, with, however, some foamy Virchow cells in one of the cases, without bacilli.

"In 1955, in the course of an autopsy on a Japanese patient dying in an exacerbation of ENL, T. Miyata (4) discovered a tuberculoid neuritis of the cubital nerve. Then in 1958 T. F. Davey (1), did not hesitate to cite the rare phenomenon of transformation of lepromatous type to borderline form on the occasion of an eruption of ENL. In the same work B. Nicholls reported a typical eruption of ENL, but without relapse in a case of borderline leprosy after 12 months of treatment with SU-1906.

"Finally E. Muir (2) freely concedes this eventuality in cases of dimorphous leprosy, as do Jopling and Cochrane (2)."

In this connection Dr. Harter records the history of two cases in 1955 and 1957 respectively, published in his paper (3), which cannot be reproduced here, for lack of space.

"For H. C. de Souza Araujo (2) the appearance of ENL almost exclusively in lepromatous patients might be explained solely on the basis of their greater density in bacilli; for him, in the final stage of healing, the ENL could be identified only in areas where there are many bacilli. Why could not this condition, and others still unrecognized, be encountered also in a borderline case close to lepromatous in type?"

-F. Harter

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