Volume 39, Number 1
Printed in the U.S.A.

CORRESPONDENCE

This department is for the publication of informal communications that are of interest because they are informative and stimulating, and for the discussion of controversial matters.

To The Editor:

I write to beg that you will give further consideration to your decision that it will be the future editorial practice of The Journal to refer to lepromatous infiltration or granuloma as a "nodule" (p. 203). "Nodule" is a useful descriptive term which is widely used in clinical practice. "Nodular leprosy," which you quote in justification, is a clinical term. "Nodule" has no particular pathologic connotation, and whereas it could be applied in a general sense to some lepromatous lesions it is inappropriate for others which are by no means nodular. How about diffuse lepromatous leprosy?

Histologically, inflammatory lesions are customarily referred to by one of three terms: *cellular infiltration* which is self explanatory; *granuloma*, which as you say is not precisely defined but in common usage means a proliferative cell mass derived from mononuclear cells; and *granulation tissue*, which is generally applied to the reparative stage, in which the lesion consists of new capillaries, fibroblasts and a varying proportion of inflammatory cells. Like other mycobacterial lesions, those of leprosy have two components, one proliferative and the other infiltrative, and though one or the other predominates there is normally a mixture in some degree. This applies both to the lepromatous and tuberculoid forms. In the lepromatous type the degree of proliferation *in situ* of phagocytic cells depends on the degree of activity of the lesion, but in ordinary new lesions a majority of the cells probably owe their origin to infiltration. Certainly the manner of spread is infiltrative and as a result the lepromatous mass is irregular, somewhat dispersed and seldom nodular. But if, after regression, there is a recrudescence of the infection, fresh infiltration into pre-existing lepromatous masses comes about and is followed by a phase of hyperactivity and cell proliferation *in situ*, with the production of an expansile type of spread. Such histoid lesions could be described as nodules. They could also, I think, be described as granulomata. *Granuloma* and *histoid* both mean tumor or tumor-like.

Whether the average leproma would be better described as *granuloma* or *infiltration* is a matter of opinion and descriptive convenience. But, please, not a *nodule*. In your editorial you make much of the "immunologic dichotomy" of leprosy in support of your views. In fact, the continuous gradation of the spectrum is precisely the reason why there is need for a histologic term that can be applied, if possible, to a lesion irrespective of its classification. *Tuberculoid, lepromatous,* etc., are sufficient to indicate its immunologic status.

—D.S. Ridley

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[We have no general disagreement with the views expressed by Dr. Ridley and are well aware of the spectrum of inflammatory changes which are seen from one leprosy pole to the other. The gradations between these poles are so subtle and gradual that they defy precise histopathologic classification. There is, however, quite clearly discernible differences between the histopathologic manifestations as well as the immunologic expressions of the two poles in leprosy. These being the extremes they present convenient contrast for study and discussion, and understanding does not require classification of all the gradations in

between when it is recognized that these are apparently to a considerable degree varyingly emphasized mixtures of the expressions seen in the two polar types. For this reason we, in common with many other workers, stressed these differences in order to make the major point in the editorial referred to. This point was that the leprosy model seems to provide indication of a better understanding of the immunologic-pathologic nature of granuloma formation in chronic infectious disease. We essayed the opinion that the usual histopathologic presentation in the lepromatous leprosy is sufficiently different to warrant the recognition by not using the term granuloma indiscriminately in association with any leprous inflammations. We hold these concepts to be valid.

It is not our editorial intent to violate any dissident opinions held by authors submitting manuscripts. The edited manuscripts are returned to the authors for their final comment before publication. We intend to suggest the use of alternate terminology for their consideration if it seems appropriate. In place of the use of the word granuloma for lesions which are clearly lepromatous we intend to suggest the use of alternate designations such as nodule or leproma for the consideration of the authors. The intent of the editorial was not to indicate any attempt at dictatorship over the concepts authors might wish to express but to indicate that there seems to be here a valid message from leprosy which might contribute to a broader understanding of this area of inflammatory manifestation and to suggest that an awareness of this problem in leprosy would be likely to bring such understanding more readily to the forefront.—THE EDITOR]