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## THE ABORTIVE CASE

It has long been generally recognized that in cases of neural leprosy, provided they do not become "mixed" by developing lepromatous lesions, the infection usually dies out spontaneously in the course of time. In the prevailing concept of the disease this only

occurs after the disease has advanced to such a degree that there are left permanent sequelae, often very severe. It is also recognized that spontaneous arrest may occasionally happen in cutaneous-type cases that have had little or no special treatment; for example, cases of this kind have recently been reported by Lie,<sup>1</sup> and a considerable number of them were found at Culion when the inmates were intensively surveyed in 1922. But this is of relatively infrequent occurrence, and these burnt-out cases usually show notable effects of nerve involvement.

Attention has been drawn of late to the so-called "abortive" case, in which the situation is very different. This term applies to cases in which the disease advances to only a limited degree and then, without medical intervention, ceases to progress and the changes (macules or areas of anesthesia) remain stationary or retrogress partially or completely, the infection presumably dying out. That there are such cases seems beyond question. They seem to be most frequent in young people, and apparently pertain only to the neural form of the disease; as far as one knows this termination has not been described for cases whose lesions were bacillus-positive and lepromatous. It appears that in India, where leprosy cases show on the average a relatively high resistance to the infection, abortive cases<sup>4</sup> are especially common, and the leading workers there have made particular note of them.

That such cases are important where they are at all common can hardly be questioned. It appears that their occurrence in numbers does not necessarily mean a low incidence of infection, but on the other hand, given a certain total incidence of leprosy, any important number of abortive cases must signify a relatively decreased degree of severity of the endemic. There will be fewer patients that become crippled or that should be hospitalized. Cochrane<sup>2</sup> has emphasized this aspect of the matter, pointing out that in attempting to obtain an idea of the importance of the disease in a given region it does not suffice merely to enumerate the cases, for where many of them are of the slight, abortive kind the total figures may give an exaggerated notion of the situation. The whole matter seems worthy of special consideration where serious work with leprosy is being done, and in this connection attention is drawn to an inquiry by Dubois, else-

<sup>1</sup> Lie, H. P. The curability of leprosy. *Internat. Jour. Lep.* 3 (1935) 1.

<sup>2</sup> Cochrane, R. G. The epidemiology and prevention of leprosy. *Internat. Jour. Lep.* 2 (1934) 385.

where in this issue (page 357), induced by observations in the Belgian Congo, and to comments thereon by Cochrane and Rodriguez.

A question is raised by Fraser (also in this issue, page 360), as to how a truly abortive case, in which the infection has actually been overcome, can be told from one in which it is merely quiescent and liable to become active again upon provocation. Evidently there is no known method of making the distinction definitely. The leprolin test cannot help, for it would be expected to give a positive reaction in either case. In South Africa—where isolation is not limited to cases that are bacteriologically positive—when a patient with one or a few apparently inactive, uninfiltated macules is put under observation, potassium iodide is administered as a test. If a reaction occurs, manifested by reddening of a lesion or any part of it (usually when this occurs it is in the margin, and perhaps only a portion of it), the patient is isolated as at least potentially active; those that remain quiescent are allowed to return home. However useful this test may be for its purpose—in spite of an occasional case that is seriously injured by it—there is a decided element of uncertainty in the procedure. Only a systematic, repeated and prolonged follow-up can give assurance that the cases that do not react to the drug may not experience reactivation of the disease later, and no report of such an investigation has been seen.

From what has been written, it is clear that only time can tell whether a given case is abortive or not. If a patient gives a reliable history that the macule or anesthetic area found has been completely inactive or more or less retrogressive for a period of several years, the presumption seems justified that the case is abortive. Both Cochrane and Rodriguez seem agreed that an inactive period of three years is at least suggestive, though Rodriguez and Plantilla in an article to appear in the next issue, insist that a neural case must be observed for from ten to twenty years before it can be said positively that it will not become reactivated. This question is one worthy of special attention by all who are dealing with such cases, as is also that of what should be done in the way of treatment in cases of uncertain status.

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