

## 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.*

## Importance of Nasal Involvement in Leprosy

TO THE EDITOR:

I would like to comment on the article by Shehata *et al* (7).

While the intention to, "fill a gap in the leprosy literature," is wholly admirable it is unfortunate that the, "detailed clinical picture of the disease in the nose," which they seek to present, far from being clear, is muddled and in parts wrong.

The first important omission is that no mention is made of how the diagnosis of leprosy was made in the patients studied, nor how these patients were classified into three clinical types.

A high proportion of nasal involvement in lepromatous leprosy is in accordance with other published series (2,6) but the statement that 72 out of 80 (90%) patients with tuberculoid leprosy had nasal involvement can only mean that, if the clinical observations of the nose were correct, then the classification was wrong. In over 300 cases personally examined, of which more than 50 had tuberculoid leprosy, no involvement of the nasal mucosa was substantiated clinically, bacteriologically or histologically even when a tuberculoid patch involved the skin of the nasal vestibule (3).

Next, it is difficult to understand how the statement in the discussion beginning: "The nose was found to be involved in as many as 97% of leprosy patients . . .," is thought to give support to a postulation by Lagoudaky that, "the nose is not essentially the channel of contraction of the disease nor the first organ to suffer." In a series of 34 cases of lepromatous leprosy it was shown that nasal infection occurred very early in the disease process and was often much greater than might have been suspected from observation of the systemic signs (5). Although it may well be that the nose is not in fact, "the channel of contraction," in leprosy, it is of

great importance in early lepromatous leprosy and, as the most potent source of exit of viable *M. leprae* from the body, it is probably the route by which the infection is spread (4).

Finally, in lepromatous leprosy, hyposmia occurs in 43% of patients whereas it is not normally a feature of borderline or tuberculoid leprosy (1).

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Reply: *Thank you for referring the letter of comments by Dr. Barton on our article "Leprosy of the Nose, Clinical Reassessment" (4) to which we have given our fullest attention.*

*The diagnosis of leprosy was certain considering that our cases were inpatients in the Alexandria Leprosarium Hospital where cases are admitted only after thorough clinical examination and investigations and are repeatedly subjected to meticulous clinical and bacteriologic studies.*

Cases were classified according to the system adopted by the Sixth International Congress of Leprosy, Madrid 1953 (2), based on the clinical features, histopathologic examination of skin lesions, bacteriologic examination of nasal smears for acid-fast bacilli and lepromin testing. Since our study was particularly intended to explore nasal involvement, it was felt unnecessary to dwell on these findings. The findings only served as a preliminary step for correlating the clinical type with the nasal picture.

The high percentage of nasal involvement in patients with tuberculoid leprosy was a fact actually present in our studied cases and is in accordance with many published studies (1,2). If this finding contradicts with that of Dr. Barton, one should think of many changeable factors such as the duration of the disease, sex, race and other personal factors.

The statement in the discussion postulated by Lagoudaky (3), that the nose is not essentially the channel to contraction of the disease or the first organ to suffer, was mentioned to explain the finding of 3% of our cases were free from any nasal affection, and also the result of the personal experiment in which Dr. Lagoudaky inoculated himself with infected blood and got the disease without any nasal affection.

We do agree, Dr. Barton, that the nose is of great importance in early lepromatous leprosy and is the most potent source of exit of viable *M. leprae* from the body and is probably the route by which the infection is spread.

The affection of smell sensation in leprotic patients could be by the mechanical obstruction of the nose by the excessive crusts and discharge which disappears by simple nasal cleaning or by involvement of the olfactory nasal mucosa which is a rare finding of 1.2%, hence we believe that the 43% of hyposmia in Dr. Barton's series comprises the two groups of patients.

Finally we would like to say that the majority of our studied patients and other new ones are in the Alexandria Leprosarium under treatment and they are available for any clinical, laboratory or histopathologic research studies and Dr. Barton will be most welcome at any time to come and share in any suggested work.

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