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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. The mandate of this JOURNAL is to disseminate information relating to leprosy in particular and also other mycobacterial diseases. Dissident comment or interpretation on published research is of course valid, but personality attacks on individuals would seem unnecessary. Political comments, valid or not, also are unwelcome. They might result in interference with the distribution of the JOURNAL and thus interfere with its prime purpose.

DDS 100 mg Daily Preventing Permanent Nerve Damage in Reversal Reaction

TO THE EDITOR:

The article "Reversal reaction: The prevention of permanent nerve damage. Comparison of short and long-term steroid treatment" ([3]) was read with much interest because I was involved in the management of these reactions at the Addis Ababa Leprosy Hospital (ALERT) from 1969 up to 1971. From this experience and from my present position as internist at the same hospital I feel justified to make a few comments.

The conclusion that prolonged steroid treatment was shown to be superior to short term treatment is not based on solid arguments gained from a controlled study. Therefore the results should be interpreted with caution, and the conclusion can only be preliminary. Comparison of results from a prospective study with those from a retrospective can easily lead to biasing past observations ([2]). The authors have not been successful in preventing this methodological fault because they require a sufficient number of voluntary muscle tests (VMT) to be available from cases seen in 1969–1973. By this requirement the very mild neuritis cases in that period are excluded, which is demonstrated in Fig. 1 of the article. The higher mean VMT deficit in the so-called mild neuritis from 1969–1973 is explained by the exclusion of the very mild ones. For example, a patient seen in 1970 with bilateral tender ulnar nerves and slight weakness of both mm. abd. dig. min., i.e., a VMT deficit of 2 or 4 was requested to come back after 2 or 3 weeks of steroid treatment. At that second visit the doctor in charge of the neuritis clinic looked for nerve tenderness and tested the strength of the afflicted muscles. If no abnormalities were noted, the neuritis was considered to be cured and the VMT was not repeated. These cases are excluded by the requirement of a sufficient number of VMTs and explain the poor therapeutic results in the period 1969–1973, which are given in Table 3 of the article.

Regarding the statement that prolonged steroid treatment, i.e., prednisone for more than 3 months has proven to be superior, insufficient data have been presented. The improvement of VMT deficit after the first 3 months of treatment in severe neuritis from 20 to 7.5 (period 1974–1978) versus 30 to 12.5 (period 1969–1974) is in my opinion insufficient to claim that BL patients should get prednisone for 18 months.

The authors have only been able to demonstrate that severe neuritis in the period 1969–1973 responded less well in the first 3 months of treatment than in the period 1974 to 1978. However, it is simplistic to conclude that this success is due to a difference in steroid dosage. In the 2 observation periods there was also a difference in DDS dosage. From 1969 up to 1972 all patients were treated with DDS 200 mg weekly; in 1973, a gradual change in DDS dosage took place, and from 1974 the patients were treated with DDS 50 or 100 mg daily. Because DDS in daily dosage has

been suggested to prevent borderline leprosy reaction ([1]), one may question if the better treatment response from 1974–1978 was not in part due to the increase of the DDS dosage. Hence the provocative heading of this letter, which only illustrates that a controlled trial is needed to prove the value of long term steroid treatment in reversal reaction.

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