Reply to Dr. Rabello, *et al.*'s Letter to the Editor

TO THE EDITOR:

My letter entitled "Should indeterminate leprosy ever be diagnosed" ([3]) was meant to stimulate your readers, and in my answer to Dr. Browne's defense I pointed out that from what was written in India and the Philippines, as well as from Africa, it is clear that different authors use the diagnosis in different ways ([4]).

South America has now joined the fray ([5]). Dr. Rabello and his colleagues quote a paper ([1]) in which 41% of indeterminate cases persisted as such during clinical and immunological follow up for 23–35 years. I quoted a paper ([2]) in which 2749 cases all regressed spontaneously. Does Dr. Rabello really believe these papers were discussing the same thing?

Moving on to another tack, they remind us that "scarceness of a specific agent in infectious cutaneous lesions cannot be considered unusual." I agree, but in the cases they mention, tuberculosis and syphilis, there are other findings (histological, clinical, immunological, etc.) to support the diagnosis. I believe that many reported cases of "indeterminate" leprosy do not have any other evidence to support the bacteriologically unproven suspicion. (If other evidence is available, the disease is no longer indeterminate.)

"It is impossible," they state, "that a child in the same endemic area with the same type of macule is free from any known disease." That is, of course, true, but why do they think the only possible diagnosis is leprosy?

It seems they are prepared to diagnose leprosy in every hypopigmented lesion occurring in all endemic areas. To me this savors of guilt by association—I prefer concrete evidence.

When Dr. Rabello and his colleagues see a child with a) a white patch, b) no detectable leprosy bacilli, c) a nonspecific histology, and d) a negative lepromin test, it seems they are prepared to tell the parents that the child has leprosy. I am not.

They suggest that I deny patients the benefit of sulfone treatment. This is nonsense; I simply do not give antileprosy therapy to people unless I am sure they need it.

—John H. S. Pettit, M.D., F.R.C.P.

Room 303
China Insurance Building
174 Julan Tuanku Abdul Rahman
Kuala Lumpur, Malaysia

REFERENCES

1. Alchorne, M. *Evolução de hanseniase em 38 enfermos submetidos à reação de Mitsuda hà 23 a 35 anos. Valor prognóstico da reação,* thesis, Recife, Brazil, 1974.
2. Browne, S. G. Self-healing leprosy—report on 2749 patients. Lep. Rev. **45** (1971) 104–111.
3. Pettit, J. H. S. Should indeterminate leprosy ever be diagnosed? Int. J. Lepr. **49** (1981) 95–96.
4. Pettit, J. H. S. Reply to Dr. Browne's Letter to the Editor. Int. J. Lepr. **50** (1982) 224.
5. Rabello, F. E., Azulay, R. D., Belda, W., Garrido Neves, R. and Pereira, A. C., Jr. Again on "indeterminate leprosy" (alias immature hanseniasis). Int. J. Lepr. **51** (1983) 418–420.