Response to Dr. Pfaltzgraff

TO THE EDITOR:

Browne [1] in his original clinical studies with clofazimine reported that of 26 patients, 21 of whom were treated for only 6 months, only 2 developed erythema nodosum leprosum (ENL). When clofazimine was discontinued, 14 of them developed ENL. Thus, he concluded that clofazimine exerted a suppressive effect on ENL. Pettit [9], recognizing the inherent difficulties in assessing the influence of agents on diseases such as ENL with naturally fluctuating clinical courses, devised a method for clinical trial of agents being assessed for their activity against ENL and found clofazimine 100 mg 6 days a week without effect. Others [6, 7] have, however, found it to be of measurable effect generally at higher doses. The World Health Organization [11] concurred that in very severe ENL, even at dosages of 300 mg daily, clofazimine may not be as effective as corticosteroids or thalidomide. In the treatment of ENL [3–5], we maintain and most authorities [2, 8] agree that clofazimine is a second-line drug whose application is sorely limited by its slow onset of action, generally requiring 4–6 weeks. Thus, in acute type 2 reactions it is of little value, and its place in the therapy of chronic and recurrent ENL is to facilitate reduction in the dose of chronic corticosteroids that is required for control. Although clofazimine is considered generally to be even less reliable in controlling type 1 reactions [8], Pfaltzgraff [10] in an uncontrolled study of borderline and tuberculoid patients concluded that clofazimine was effective in controlling neuritis. Because in the lepromatous case which we reported very high doses of corticosteroids and thalidomide, which are both known to act more rapidly than clofazimine, were initiated and maintained from the earliest sign of reaction, we do not believe that clofazimine would have altered the course in this patient.

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