Response to Comments by Dr. Pannikar

TO THE EDITOR:

We are quite aware that the World Health Organization-recommended multidrug therapy (WHO/MDT) is to prevent the selection of drug-resistant *Mycobacterium leprae* mutants and to improve compliance with treatment of patients by shortening the duration of treatment. The introduction of new antileprosy chemotherapy is still a need felt by many for reasons such as further shortening the duration of treatment.

Investigators have shown in mice that brodimoprim has profound synergism with dapsone against *M. lufu* (a species closely related to *M. leprae*) infection in killing even dapsone (DDS)-resistant bacilli.

Our patient was thus enrolled in the brodimoprim trial and received a 3½-month, short-course therapy. Due to her low response to this treatment, however, we had to resort to the treatment as mentioned in the paper, according to ALERT's Hospital policy for the management of highly infectious lepromatous leprosy patients coming from areas where MDT is not as yet implemented.

During the second episode of erythema nodosum leprosy, although the bacterial index reduction was not foreseen, the clinical improvement and the morphological index (MI) was expected to fall to zero, when treated with bacteriostatic drugs, let alone with a rifampin-containing regimen.

Contrary to our assumption, there was no clinical improvement and the MI remained as high as 4% at some sites. In view of 3 weeks of supervised daily rifampin, clofazimine and dapsone + daily dapsone and

clofazimine self-administered for 4 months and followed by 2 months of WHO/MDT and the MI remaining high, at this particular time we could only assume that the patient was harboring multiple-drug resistant *M. leprae*. A mouse foot pad sensitivity study to DDS, rifampin and clofazimine was carried out while the patient was continued on daily rifampin, clofazimine, dapsone and ofloxacin in combination, ofloxacin being given only for 3 months.

To summarize, our patient was on brodimoprim monotherapy for 3½ months for trial and, in retrospect, on clofazimine monotherapy for 4 months because she was found to be fully resistant to dapsone at the end. Our patient has never had either rifampin or ofloxacin as monotherapy.

Indeed, our patient had received intensive WHO/MDT with additional ofloxacin. As we have tried to explain here and in the paper, we hope Dr. Pannikar will realize that we did not do a sequential treatment for our patient.

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