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CORRESPONDENCE

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Relapsing Multibacillary Leprosy—A New Dimension to Transmission in Urban Areas

It is very well known that a bacterial disease cannot be eradicated by chemotherapy alone. Although leprosy has come under control after the advent of multidrug therapy (MDT), several factors still have to be considered in breaking the chain of transmission. Besides hidden, untreated, skin smear-positive cases, the contribution of patients relapsing with multibacillary (MB) leprosy with positive skin smears (irrespec-

TABLE 1. *Relapses in relation to duration of follow up.*

Treatment	No. patients	Follow up after RFT (yrs.)		
		5–8	9–12	13–16
FDT 24	76	43	26	7
FDT 12[a]	45	37	8	—
Total	121	80	34	7

[a]FDT = Fixed duration therapy; 1 patient has relapsed.

TABLE 2. *Relapses in relation to mean duration.*

Treatment	No. relapses	Duration after RFT (mean yrs.)
MDT >24	12	11 1/12
FDT 24	5	9 4/5
FDT 12	1	8
ROM 1	2	2.10
RO	3	3

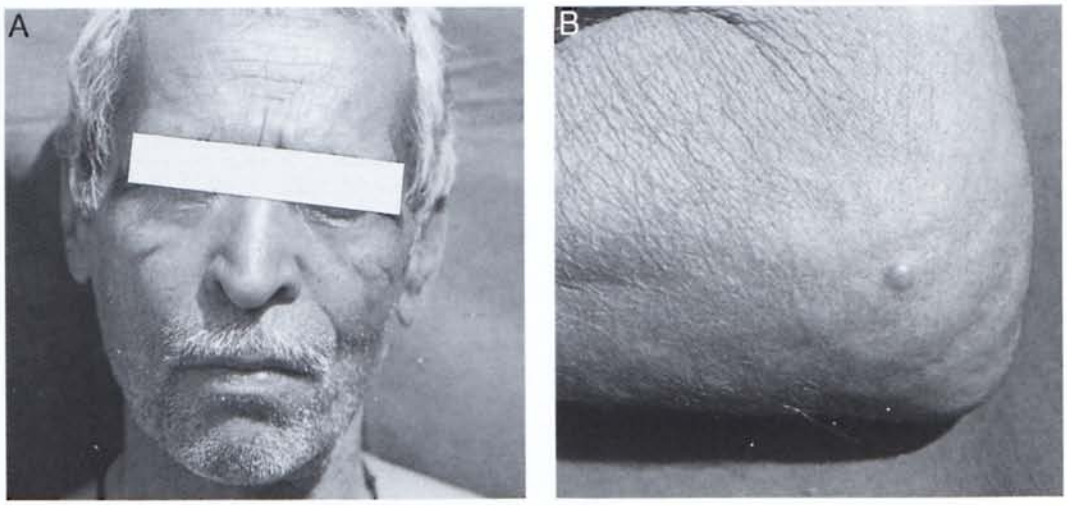


FIG. 1. **A** = Patient receiving extended MB-MDT; **B** = Relapse 12 years after stopping treatment.

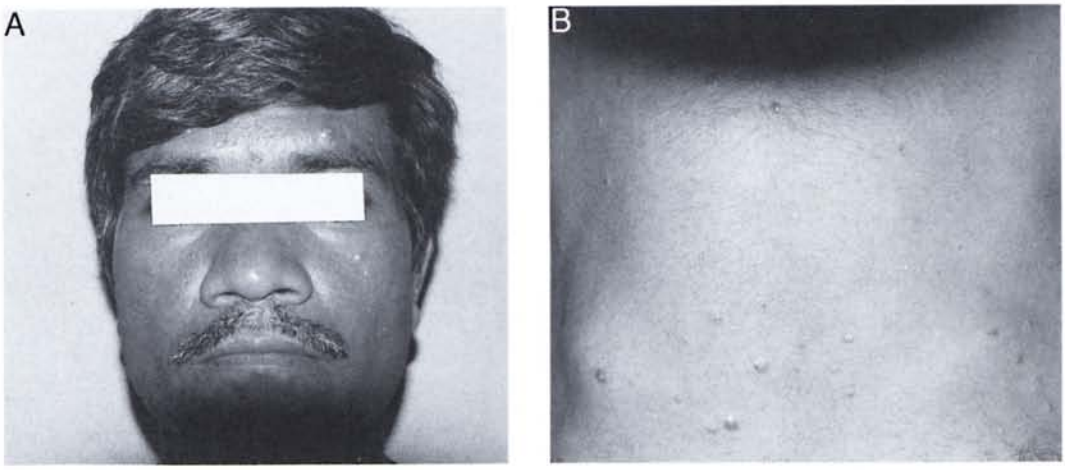
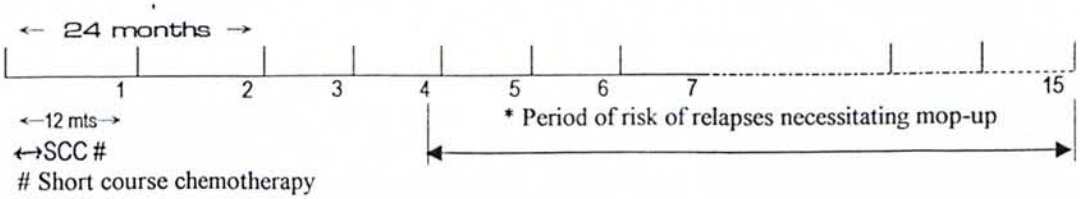


FIG. 2. **A** = Patient receiving 12 months of MB-MDT; **B** = Relapse 8 years after stopping treatment.

tive of their degree of positivity) has not been adequately documented at the population level. Although relapses are few in relation to the number of leprosy cases completing the treatment and those relapses are all re-treatable, this phenomenon brings a new dimension to the "hidden" aspects of transmission of leprosy, particularly in densely populated cities.

It is surprising that in our experience only 1 case relapsed 8 years after release from treatment (RFT) out of 121 MB cases whose initial bacterial index (BI) was more than 3+ and who were followed up for periods ranging from 5 to 13 years (Table 1). On the other hand, it is also true that cases with sporadic relapses eluding attention keep reporting voluntarily, well beyond the specified surveillance period, posing a threat of transmission (Table 2, Figs. 1 and 2).

Many patients in this group had received MDT for many years beyond the period of skin-smear negativity (some were on dapsone monotherapy prior to MDT). In our opinion relapses seem to occur, as indicated in the following schematic diagram representing a span of 15 years:



*Unfortunately, it is during this risk period that 1) there is a severe lack of field manpower and 2) patients are likely to be missed both in a highly urbanized setting as well as in difficult rural terrain. It is a paradox that at the most crucial stage after induction of the treatment, the program loses its hold on the disease due to logistics when the disease management demands serious attention and substantial financial support. If "retrieval" is not planned, one may never understand the course of this chronic disease and, as a consequence, the very soul of leprosy work will be lost.

The solution to such a problem is to undertake a "mopping-up" exercise, if one is to identify these relapses before they spread the infection to a large segment of the urban population.

—Dr. R. Ganapati
Dr. H. O. Bulchand
Dr. V. V. Pai
Mr. S. Kingsley
Dr. C. R. Revankar

Bombay Leprosy Project
Vidnyan Bhavan
11 VN Purav Marg
Sion-Chunabhatti
Mumbai 400 022, India