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CORRESPONDENCE

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A Need for Clarification of the Classification Criteria for Leprosy Patients

TO THE EDITOR:

We read with interest the article by Gelber *et al*. ([1]) in the December 2004 issue of THE JOURNAL, in which they observed high relapse rates in MB leprosy patients with high initial bacterial indices (BI). Even though we agree with the conclusions from the article, we were surprised to see the following phrase in the discussion:

". . . classifying patients as MB or PB. This distinction is now determined simply by counting the number of skin lesions, MB being ***5 or more*** (our emphasis) *and PB being less."*

This is actually a misinterpretation of the WHO guidelines and our field experience has indicated that this mistake is often made in leprosy control programmes:

The actual WHO classification criteria are: more than 5 lesions for MB ([2–7]) and 5 lesions or less ([2–4,6,7]) or "*up to five*" ([5]) for PB. As "more than 5" in our experience is regularly interpreted as "5 or more" by field workers (and apparently also by the distinguished research group at the Leonard Wood Memorial Center in Cebu), we suggest that the recommendation be re-stated to state: "**6 or more**" for MB leprosy and "**5 or less**" for PB leprosy in all protocols and reports.

In the case of the article by Gelber *et al*. ([1]) we are aware that the above misinterpretation of the WHO guidelines for classification had no influence on the outcome or interpretation of the study results. This is because they made use of BI determinations and Ridley and biopsies classified according to the Ridley-Jopling system. This lack of any effect on the results may make our point appear trivial, but if standard criteria are not used in published studies it undermines attempts to standardize criteria in the field.

The same phrase mentioned above also states that classification is determined by *". . . simply counting the number of* ***skin lesions*** (our emphasis)". Actually, in our opinion the information provided by WHO is confusing on this point:

In some documents ([2,4,7]), dating from 1995 and 2005, the inclusion of enlarged or damaged nerve trunks in the classification of leprosy is advised, with more than one involved nerve leading to classification as MB.

In other documents ([3,6]), dating from 1997 and 2000, classification is solely based on counting skin lesions.

We know from experience that in some leprosy control programs skin lesion counting is the only classification criterion used, while in other programs nerve involvement is included as well. Even within one country different control programs may use different classification criteria, making it extremely difficult to compare data from different programs, such as PB/MB ratios.

The above observations emphasize the need that WHO gives clear and consistent criteria and that the those who collect and analyze the data (government officials, clin-

icians, leprosy control officers and researchers) use unambiguous phrasing of classification criteria in protocols and reports to prevent misinterpretation, especially among people for whom English is not the first language and/or for health workers in the field who may have relatively limited education.

It also emphasizes the importance of a detailed description of the exact classification criteria used in leprosy studies where classification of the leprosy patients is important for the interpretation of study results.

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