Correspondence

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.

REFERENCES


7. WHO Regional Office for the Western Pacific. 2005. URL: http://www.wpro.who.int/sites/leprosy/leprosy_wpr/leprosy_classification.htm

—Dr. Linda Oskam
—Dr. Samira Bührer-Sékula

KIT (Royal Tropical Institute)
KIT Biomedical Research
Meibergdreef 39, 1105 AZ Amsterdam
The Netherlands.

Dr. Gelber and Colleagues Reply

We entirely agree with the errors noted by Dr. Oskam and colleagues concerning our mistake regarding the number of skin lesions required by the WHO for the classification of MB leprosy, as well as their comments concerning the WHO’s conflicting statements concerning nerve trunk enlargement and damage in classifying leprosy cases. Furthermore, we agree that clarity in classification standards is necessary.

In our report, the utility of counting lesions for classification, and not skin smears or histopathology, was criticized for its potential to fail to identify those leprosy cases with a high BI and who are BL or LL, these having been established as at high risk for relapse. Though Scollard (1) has recently and eloquently described in detail the importance of skin smears and proper histopathologic classification in research papers, there are 2 additional reasons clinicians require smears and biopsies for classification:

1. We have found over 1/3 of our patients who would be classified as PB by counting lesions are in fact BL or LL with an average BI (6 sites) of 2.3 (unpublished observations). Such patients at many centers would be treated, we believe inappropriately and to their detriment, with the PB regimen. Fortunately, in Cebu, we still use skin smears and biopsies for leprosy classification, and these patients are treated as MB leprosy.

2. In our MB patients an increasing BI is associated with an increased risk of reactional states after the completion of MDT, occurring particularly frequently in those treated with 1-year MDT as opposed to 2-year MDT and after 1-year MDT in 48% of patients in the first 2 years after the completion of therapy (manuscript submitted for publication). Skin smears could thus prove particularly useful in assisting to re-define when patients can safely be released from control.

In conclusion, for those treating leprosy patients, skin smears and biopsies classified by the methods of Ridley and Jopling have are advantageous methods, compared to counting lesions, in predicting which patients are at risk for relapse and avoiding under-treatment, and in identifying patients
at high risk for reactional states after the completion of MDT.


—Maria Balagon
—Rodolfo Abalos
—Tranquilino Fajardo
—Fe Pardillo

The Leonard Wood Memorial Center for Leprosy Research
Cebu City, Philippines