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patients who would be classified as PB by counting lesions are in fact BL or LL with an average BI (6 sites) of 2.3 (unpublished observations).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 competion 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.

1. SCOLLARD, D. M., Classification of leprosy: a full color spectrum, or black and white? Int J Lepr Other Mycbact Dis. (2004) 72:166–8.

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