Letter to the Editor

HOT TOPICS IN LEPROSY

Editor

A recent report of the ILA Technical Forum (Lepr Rev, 2002, June, Supplement) provides an excellent review and recommendations on many controversies/problems in leprosy. We wish to congratulate all the participants of this technical forum for their landmark work and valuable contributions. We understand that it is not feasible to cover every aspect of leprosy in such a forum; however, there are certain important issues that require the immediate attention of experts in the field of leprosy. We endeavour through this letter to highlight some of them.

Corticosteroid regimen in reversal reaction

Corticosteroids remain the drug of choice in the treatment of reversal reactions (RRs). According to the World Health Organization (WHO), the recommended dose is 40–60 mg daily, gradually reduced weekly or fortnightly and stopping after 12 weeks. The chief effect of corticosteroids is to suppress the T-cell driven inflammatory response to Mycobacterium leprae antigens within the skin and nerves. Therefore, it is argued that immunosuppressive doses of corticosteroids are required for prolonged periods, as the reaction will persist whilst the bacillary load gradually falls. Rose and Waters and Naafs have recommended that most BT patients require prednisolone for 4–9 months, BB patients for 6–9 months and BL patients for 6–18 months or even 24 months. Twelve weeks of prednisolone therapy for RRs in BB/BL patients has been found to be inadequate, with one-third of patients relapsing. Extension of therapy to 20 weeks has, however, resulted in a low recurrence rate. These existing reports provide conflicting data regarding adequate duration of steroid treatment in RRs. We suggest that a 6 months regimen to be tapered as per individual requirement with a ± factor of 3 months should be studied.

Treatment of nerve function impairment (NFI)

Damage to the nerve due to influx of inflammatory cells and their mediators is generally responsible for acute NFI. Demyelination occurring as a sequel to atrophic changes in the axonal component and physiologic damage due to persistence of mycobacterial antigen in the Schwann cells or axons is responsible for more diffuse, insidious and gradually progressive NFI. Within what period after the onset of nerve damage should corticosteroids begin, and how long to continue, remains unanswered. WHO states that all neuritis of less than 6 months duration should be treated with the standard 12-week regimen of oral prednisolone. Patients with recent NFI of <6 months duration demonstrate greater improvement in nerve function than those with old impairments. However, Van Brakel and Khawas did note significant improvement in sensory function after 3 months prednisolone therapy in some patients with NFI of 6 months duration. According to some leprosy workers, the maximum improvement occurs in the first 3 months, but may continue for up to 6 months. It may be argued that NFI treated
‘early’ should respond better to treatment than when treated ‘late’, but very little evidence for this could be found in the literature. More studies are needed to define the group of responsive patients, adequate length and dosage of corticosteroids more accurately.

Number of peripheral nerve trunks involved—classification and treatment

According to recent WHO guidelines, patients with \( \leq 5 \) patches are classified as PB and if there are \( > 5 \) patches, the disease is classified as multibacillary. However, these guidelines have conspicuously ignored the number of peripheral nerve trunks involved. In PB patients who have \( \geq 2 \) peripheral nerve trunks involved in different limbs, it is possible that disease classification solely on number of skin lesions may be misleading, resulting in patients actually being under-treated with the PB regimen. Such patients may benefit more from an MB regimen.

Primary neuritic leprosy—classification and treatment

Primary neuritic leprosy presents as peripheral nerve trunk involvement without any skin lesions and a negative SSS from the area of sensory loss. There are no guidelines from WHO about the classification of these cases depending upon number of nerves involved and therefore treatment. Well-planned studies are required to formulate the right MDT regimen, taking into account such aspects as the number of involved nerves trunks, cutaneous nerve twigs and anatomical distribution.

There is little doubt that the progressive simplification of diagnosis and treatment techniques has helped to facilitate the reaching out of leprosy services to more and more leprosy patients; however, continuous efforts to discuss and rationalize the recommendations are required. We are sure that there will be many more queries in the mind of leprosy care providers. Our effort is to highlight some important ones and to emphasize the need for continued leprosy research in grey areas.

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References