of the bacillus into nine-banded armadillos (Kirchheimer-Storrs).

Even though Shepard's model has been known since 1960, practically no antileprosy drug has been discovered through its use; and because of this it is very doubtful that such an event may happen sometime in the future.

The method of Kirchheimer-Storrs is not suitable at all as a screening method for antileprosy drugs. It is not practical, is very expensive, and it is not possible to use many animals—a condition of fundamental importance when screening methods are concerned.

Due to these facts, these two methods have been the subjects of many criticisms. We suggest instead the following method: to investigate the *in vitro* antioxidant activity of biologic as well an industrial antioxidants by using as substrate, that is, the fatty material, a synthetic mixture of fats quite similar to the human subcutaneous fat of leprosy patients, or of normal persons living in countries where leprosy is highly endemic. From the most powerful antioxidants found to act upon such fats it would be advisable to test their antileprosy activity in patients.

—Professor Meny Bergel

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No Enforced Segregation in Australia

To The Editor:

I would appreciate your publishing the following in reply to the review which appeared in the Current Literature section of the IJL in Volume 46 of 1978, page 232: comments by Dr. Lechat on the article "Exorcising the Leper" which was published in the Medical Journal of Australia (**2** [1977] 345-347).

The article quoted above has already been discussed and has a reply from the Director of Health, Northern Territory Division of the Australian Department of Health (Med. J. Australia **2** [1977] 652). This reply points out the inaccuracies of the original article from which Dr. Lechat quotes. Since the reply was published before Dr. Lechat's comments, it would have been preferable that he consulted the source before writing his own comment as it leaves one with the impression that segregation could still be in force in the Northern Territory. Nothing could be further from the truth. I would like this clearly stated: THERE IS NO ENFORCED SEGREGATION IN THE NORTHERN TERRITORY OF AUSTRALIA.

The confusion could have arisen because I was not in Australia when the original article was published, but I wrote to Dr. Gurd, who signed the article in reply as soon as it came to my notice. I think I also sent you a copy but am not sure of this. I must point out that I am very concerned about the inaccuracy of the original article and I am sure, knowing Dr. Lechat, that he will agree with me of the importance of clearing the matter up.

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Features of Ridley-Jopling Classification and Its Application in the Clinical Field

To The Editor:

I would like to draw attention to certain features of the Ridley-Jopling classification and its application in the clinical field. Originally the Ridley-Jopling system of classification (1966) was based on histopathologic findings of biopsy specimens from different types of leprosy lesions. However it might better be called a slide classification of a particular biopsy section and varies from biopsy to biopsy with respect to histologic features of BB, BT or BL. Borderline leprosy presents varied and pleomorphic clinical as well as

histopathologic features in one and the same patient or in different patients. To be more explicit borderline lesions of the same patient often present pleomorphic lesions which both clinically and histologically vary from BT, BB, BL type of clinical as well as histopathologic lesions. Even the larger single borderline lesion at times presents a BB lesion at one end and a BT lesion at the (histologically) opposite end in the same individual.

It is, therefore, evident that the BT, BB, and BL type of clinical lesions confirmed by histopathologic features have been found in one and the same individual frequently.

If this observation bears some truth then how can a BT leprosy case having the BL or BB type of lesions in his body be clinically classified as the BT type of leprosy? Almost all borderline leprosy cases exhibit lesion combinations of BT, BB and the BL type of histopathologic lesions, and for this immunologic unstable status they are placed in the borderline group. A particular histologic section of a borderline lesion can be said to manifest the BT or BB or BL type of histologic features in that particular section only. However, this precise histologic distinction may not fit properly in the apparently called BL cases in whom several BT and BB lesions are also present in their body as confirmed clinically and histologically by several biopsies from the same patients.

It is, therefore, in a fitness of things to accept the WHO classification as borderline leprosy without creating further subdivisions into BT, BB, BL, LL, etc., with special reference to the immunologic spectrum. Furthermore, one has to biopsy each and every lesion of a borderline patient to ascertain whether all lesions are BT, BB or BL type, or whether the majority of lesions will be grouped under any type such as BT, BB or BL which seems to be improbable and unpractical.

Lastly, a symposium by correspondence may be initiated on this issue to obtain the views of eminent experts working in this area.

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