Features of the Ridley-Jopling Classification

To the Editor:

Dr. S. K. Kundu (Int. J. Lepr. **47** [1979] 64–65) asserts that different lesions produce different classifications, a view which has been expressed quite frequently in the past. My own experience is based on receiving double biopsy specimens, taken concurrently from two lesions, which has been the routine practice of several of the clinicians who have sent me material over many years. In addition, I have carried out comparative assessments of the specimens of some other workers who have shared Dr. Kundu's opinion. The results are discussed in previous publications. In tuberculoid, borderline, and lepromatous leprosy, it has been exceptional to find even insignificant differences in classification between a pair of biopsies, and not infrequently the histological classification has been the same for two lesions that were clinically discrepant.

There are two provisos:

a) during reversal reactions, reacting lesions may sometimes develop at different speeds.
b) during the process of upgrading or downgrading, there may occasionally be a confusing mixture of features of BT and BL, but reactions apart, no difference, I believe, between lesions.

It is simply not true, in any general sense, that this system of classification produces different answers for each lesion. A symposium to test the views of "eminent experts," which Dr. Kundu asks for, was organized by Dr. Chapman Binford and held at the Armed Forces Institute of Pathology, Washington, in 1971, and again at Bergen before the Congress in 1973. On each occasion, agreement among the histologists participating was almost unanimous.

Neither Dr. Jopling nor I would accept that "it might better be called a slide classification." It is (opportunity permitting) a joint clinical-histological classification. Histology sometimes has the advantage on points of detail because it reflects directly the underlying immune mechanism. But the clinical assessment is always and at least a useful counterpart to histology, and in the absence of a biopsy, it stands by itself. The reason why more has been written about the histological aspects is that they are less widely understood.

—D. S. Ridley, M.D.

Hospital for Tropical Diseases
4 St. Pancras Way
London NW1 0PE, England

Features of the Ridley-Jopling Classification

To the Editor:

I have read the interesting comments by Dr. Kundu about the Ridley-Jopling classification (Int. J. Lepr. **47** [1979] 64–65). It is a fact that borderline leprosy often presents varied and pleomorphic clinical and histopathological features in the same patient. Marked variation in the LTT and immunoglobulin levels have also been noticed in borderline patients. I do agree that for field purposes the WHO classification into tuberculoid, borderline, and lepromatous is more easy and practical. However, it still remains important to have these subdivisions, which create better understanding of the disease and which make it easier to realize the concept of the leprosy spectrum. The subdivisions, which still represent the state of the patient at a certain time, are needed for follow-up of patients and for evaluation of drug therapy. In fact, when doing research, one comes to the conclusion that there is need for further subdivisions. The borderline tuberculoid (BT) or borderline lepromatous (BL) subdivision still represent different clinical, histopathological, and immunological manifestations. This has led some leprologists to in-