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Reply to Dr. Rabello, *et al.*'s Letter to the Editor

TO THE EDITOR:

My Brazilian colleagues are asking me to accept, in a classification of leprosy, the inclusion of an indeterminate form, and because I have consistently refused to accept this proposition they imply that my position is unreasonable. One of their arguments to justify their view that an indeterminate macule can be diagnosed as a leprosy lesion, in spite of absence of bacilli, is that skin lesions in syphilis may be devoid of treponemata, skin lesions in tuberculosis may be devoid of tubercle bacilli, and leprosy bacilli cannot be demonstrated in skin lesions of tuberculoid leprosy. This argument is spurious, for in these three conditions there are other ways of establishing the diagnosis; whereas there are no other ways of establishing that an indeterminate macule, free from acid-fast bacilli, is due to leprosy. The writers claim that there are "ample clinical, epidemiological and immunologic grounds" for establishing that an indeterminate macule is due to leprosy and can be classified as such; in fact, they go so far as to claim that "it seems reasonable to include these I cases ('indeterminate,' 'immature,' 'uncharacteristic' patients) in the classification of leprosy based on immunology." If this is what they really believe, then, on this question, the gulf between us is indeed great.

I maintain that a diagnosis of leprosy cannot be made on a macule in which no sensory deficit can be demonstrated, no bacilli found, and in which histologic examination reveals only a mild non-specific histiocytic and lymphocytic infiltrate. In such a case, however, a pre-leprosy condition must be suspected, especially if the patient lives in, or has lived in, a country where leprosy is endemic, provided that alternative possible diagnoses have been excluded. In such circumstances, I advocate a policy of ensuring that the patient reports for examination at regular intervals, and of instituting treatment if and when evidence of determinate leprosy is found.

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Reply to Dr. Rabello, *et al.*'s Letter to the Editor

TO THE EDITOR:

My letter entitled "Should indeterminate leprosy ever be diagnosed" ([3]) was meant to stimulate your readers, and in my answer to Dr. Browne's defense I pointed out that from what was written in India and the Philippines, as well as from Africa, it is clear that different authors use the diagnosis in different ways ([4]).

South America has now joined the fray ([5]). Dr. Rabello and his colleagues quote a paper ([1]) in which 41% of indeterminate cases persisted as such during clinical and immunological follow up for 23–35 years. I quoted a paper ([2]) in which 2749 cases all regressed spontaneously. Does Dr. Rabello really believe these papers were discussing the same thing?