of cimetidine in patients with chronic mucocutaneous candidiasis ([4]), and common variable hypogammaglobulinemia ([6]), gives cause for hope that the drug will also have some salutory effects in patients with lepromatous leprosy. However, if a clinically useful effect of cimetidine is to be demonstrated, it will be necessary to do so by *in vivo* study.

Another reason for studying the drug in a clinical trial, as we have done, is that cimetidine is a drug that is already licensed and very commonly used worldwide. We were interested to determine if the drug, used in doses commonly given to suppress gastric acid secretion, would have any adverse immunological effects in leprosy patients. In our study no effects, adverse or otherwise, were detected.

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Bilateral Ulnar Nerve Abscesses in Lepromatous Leprosy

To the Editor:

I would like to comment on the letter "Bilateral Ulnar Nerve Abscesses in Lepromatous Leprosy; a First Encounter" by Drs. Gelber and Zacharia [IJL **54**:480–482, 1986].

It is fortunate that such rapid and severe nerve involvement is unusual in lepromatous disease. I know it seems presumptuous to refer to "what might have been," but I am sure that another lesson can be learned from the unfortunate outcome of Drs. Gelber and Zacharia.

If clofazimine had been introduced into the management of this patient in doses of 300 mg daily aimed at suppressing the reaction, I am convinced that this, plus the treatment outlined by the authors, would have prevented the development of abscesses as well as the permanent nerve damage.

It is unfortunately true that clofazimine has been difficult to procure in the U.S.A., and that is possibly why it was not used in this instance. I am happy to hear that its release onto the market is imminent. Hopefully in the future it will be much more freely prescribed for implementation of multiple drug therapy (WHO) as well as for the control of all types of reactional phenomena in leprosy, both lepromatous and tuberculoid.

If this "lesson" is learned—and applied to patient management—the second and third lessons of Drs. Gelber and Zacharia may never need to be applied at all. That

is, one may not need to resort to surgical intervention and neurolysis. In management of severe neuritis of leprosy, a thorough trial of corticosteroids and clofazimine should precede any consideration of surgery, and should also be used during any surgery for nerve release.

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Response to Dr. Pfaltzgraff

TO THE EDITOR:

Browne ([1]) in his original clinical studies with clofazimine reported that of 26 patients, 21 of whom were treated for only 6 months, only 2 developed erythema nodosum leprosum (ENL). When clofazimine was discontinued, 14 of them developed ENL. Thus, he concluded that clofazimine exerted a suppressive effect on ENL. Pettit ([9]), recognizing the inherent difficulties in assessing the influence of agents on diseases such as ENL with naturally fluctuating clinical courses, devised a method for clinical trial of agents being assessed for their activity against ENL and found clofazimine 100 mg 6 days a week without effect. Others ([6, 7]) have, however, found it to be of measurable effect generally at higher doses. The World Health Organization ([11]) concurred that in very severe ENL, even at dosages of 300 mg daily, clofazimine may not be as effective as corticosteroids or thalidomide. In the treatment of ENL ([3–5]), we maintain and most authorities ([2, 8]) agree that clofazimine is a second-line drug whose application is sorely limited by its slow onset of action, generally requiring 4–6 weeks. Thus, in acute type 2 reactions it is of little value, and its place in the therapy of chronic and recurrent ENL is to facilitate reduction in the dose of chronic corticosteroids that is required for control. Although clofazimine is considered generally to be even less reliable in controlling type 1 reactions ([8]), Pfaltzgraff ([10]) in an uncontrolled study of borderline and tuberculoid patients concluded that clofazimine was effective in controlling neuritis. Because in the lepromatous case which we reported very high doses of corticosteroids and thalidomide, which are both known to act more rapidly than clofazimine, were initiated and maintained from the earliest sign of reaction, we do not believe that clofazimine would have altered the course in this patient.

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