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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Pityriasis Rubra Pilaris with Leprophobia

TO THE EDITOR:

In areas where leprosy is endemic, leprophobia compels many people with different dermatological and neurological manifestations to seek a specialist's opinion for ruling out the possibility of leprosy. Similarly, individuals with known signs and symptoms of leprosy also come to leprosy hospitals with the faint hope of not being diagnosed as a case of leprosy becase of its social stigma. Hence, it is mandatory for physicians working in the field of leprosy to be well versed with a working knowledge of the disease and of all the other conditions simulating leprosy. In the present report, a typical case of juvenile pityriasis rubra pilaris who attended Central Leprosy Teaching & Research Institute (CLT&RI) suspecting leprosy is presented.

An 11-year-old girl with multiple, progressive and well-defined erythematous plaques of 8 years' duration was brought to the outpatient department of the CLT&RI by her parents. They were worried and wanted a specialist's opinion because the girl was shunned by her close relatives and neighbors as a case of leprosy. There was no history of leprosy in the family, and she had not taken any antileprosy treatment in the past. On examination she was found to have multiple, erythematous, well-defined patches and plaques over the extensor aspects of the upper and lower limbs, face,

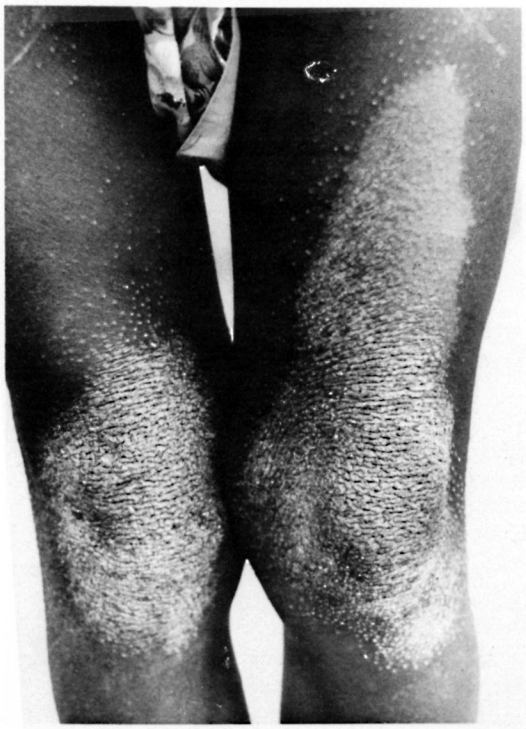

FIG. 1. Well-defined, raised, nonanesthetic plaques over both knees with surrounding follicular papules.

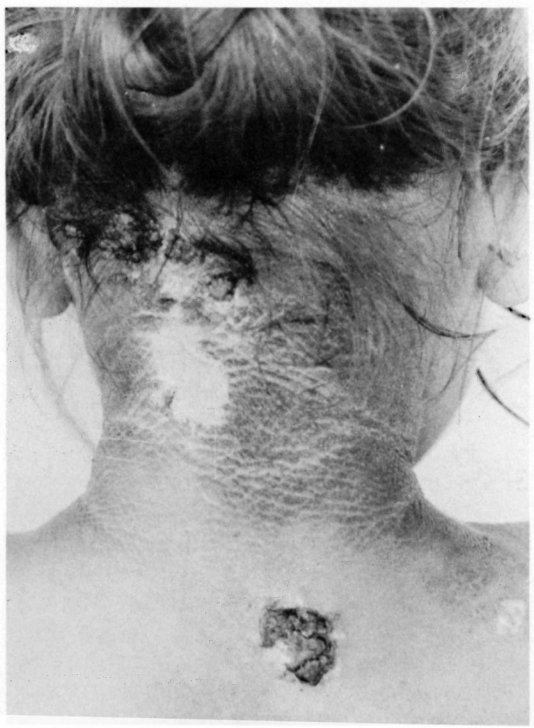

FIG. 2. Involvement of the scalp.