dermis, such as the number of inflammatory cells, the dilatation of the small blood vessels, and the degree of edema in the dermal layer. In a word, they depend on the cell-mediated immunity of the patient. If a lepromatous patient with a BI of >4.0 does not react to the numerous *M. leprae,* there will be no obvious new skin lesions at all.

I think that if there is an increase in the BI not accompanied by new lesions, the patient must be quickly re-examined by the various methods available today to confirm whether or not she/he had a relapse.

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Dr. Jamet, *et al.* Reply

TO THE EDITOR:

We read with great interest the valuable comments from Dr. Shen Jianping on our article ([1]).

Perhaps it is a reasonable approach to treat multibacillary (MB) patients with high bacterial indexes (BIs) with a longer duration of WHO-recommended multidrug therapy (MDT) if the patients are treated and followed up by a sophisticated institute, such as the Institute of Dermatology in which Dr. Shen is working, because they are able to score correctly the BI of the skin smears. Unfortunately, the quality of skin-smear service in many leprosy control programs is far below the desirable level, and it would required tremendous effort and resources to upgrade the quality of the skin-smear service. We are afraid that it would create enormous confusion in the field if the duration of MDT is variable and depends upon the average BI of the patient before starting MDT. We were very interested to learn that Dr. Shen and his colleagues had very few relapses among their many MB patients with BIs of ≥4.0. If Dr. Shen and his colleagues eventually publish their detailed results, the scientific community would benefit considerably from sharing their experience.

As described in our article ([1]), the patients of this particular group were hospitalized until completion of therapy, and all drugs, including daily dapsone (DDS) and clofazimine, were administered under supervision of medical personnel. Despite supervision, we cannot completely rule out the possibility that occasionally some of these patients did not swallow the drugs (as pointed out by Dr. Shen). Nevertheless, it is very unlikely that the high relapse rate was due to irregularity of MDT. After all, the supervision of drug administration among these patients was better than that in a great majority of outpatients.

Dr. Shen's observations and hypothesis on the relationship between previous DDS monotherapy and relapse after MDT were interesting. But, if this is the case, how does one explain that among the millions of leprosy patients who had been treated with DDS monotherapy before MDT very few of them relapsed?

Finally, we have never seen relapsed patients, especially during their later stage, who did not have obvious new skin lesion(s). In our limited experience, new lesion(s) always occur sooner or later in real relapsed cases. Of course, a suspected relapse should be kept under close surveillance, but there is no need to make a quick decision since, after all, in most cases relapse is not a clinical emergency.

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