The patient was put on standard World Health Organization multiple drug therapy (WHO/MDT) composed of dapsone, rifampin and clofazimine. An extremely favorable response to this WHO/MDT was obtained after 2½ years of therapy, with the lesions becoming inactive clinically as well as histologically. The patient was released from treatment at this time. The patient did not experience any kind of reactional episodes during the treatment or after stopping the treatment, until the date of submission of this report.

Discussion. Ramanujam and Ramu ([1]), in their masterly treatise on histoid leprosy, stated that the cutaneous histoids lack umbilication, so typical of molluscum contagiosum, but Singh, *et al.* described a case of histoid leprosy in which most of the lesions were umbilicated ([3]). In the case which I have reported here, while an umbilicated lesion is distinctly visible (lesion 1), lesion 2 seems to give the appearance of umbilication due to the coalescence of the nodular lesions arranged closely in a ring-like fashion. A very favorable response to WHO/MDT observed in this case lends credence to the view that histoid leprosy is not the offshoot of sulfone resistance for the simple reason that the patient had never taken sulfone treatment before.

The author has published this case to stress that while true umbilication may be occurring in some lesions of a histoid leproma, in the other "umbilicated" lesions it may not be a true process, and that the prognosis of histoid leproma is not decidedly unfavorable.

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Regarding Pinitsoontorn, *et al.*'s Rapid Village Survey

TO THE EDITOR:

Please allow me some comments on the article by Dr. Pinitsoontorn and colleagues about the use of rapid village surveys in Thailand ([1]).

I fully agree with the authors' view that ". . . simple and inexpensive methods can give reasonable estimates of the true leprosy situation and that can be carried out by the general health staff are highly desirable." Therefore, it must be highly appreciated that Dr. Pinitsoontorn and his team undertook to compare the rapid village survey (RVS) method to a total village survey (TVS) method.

I also agree with the authors' interpretation of the findings and their conclusion that "The RVS is a valid replacement of TVS as conducted in the Khon Kaen Province, Thailand." However, taking into consideration that "None of the suspects which were notified during the group discussion with village leaders were found to have leprosy.", I would argue that the study provided sound evidence that village surveys in which exclusively those persons self-reporting and contacts of leprosy patients are examined provide a valid replacement of TVS. I wonder what additional yield the authors still expect by the inclusion of those "suspects" in the survey sample.

Despite the apparent simplicity of this approach, it is doubtful whether any form of RVS can be carried out exclusively by general health staff without the technical assistance of a specialized staff.

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Dr. Pinitsoontorn Replies

TO THE EDITOR:

The cooperation and understanding of the village leaders in organizing a rapid village survey (RVS) is, of course, essential. We do not know if we may conclude that if a RVS were to be organized in other locations or in other countries that it would not be useful to prepare a list of "suspects." In general, when applying the RVS in other areas, adaptations for different local circumstances need to be explored.

The involvement of the general health staff has many advantages. However, technical assistance by a specialized staff (for example: training general staff, confirmation of the diagnosis in those with possible signs of leprosy, survey method design, quality control) is a must. The assistance also depends upon the numbers and availability of a specialized staff in different areas.

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