The number of patients and deaths in this study was small, and therefore the results should be interpreted with caution.

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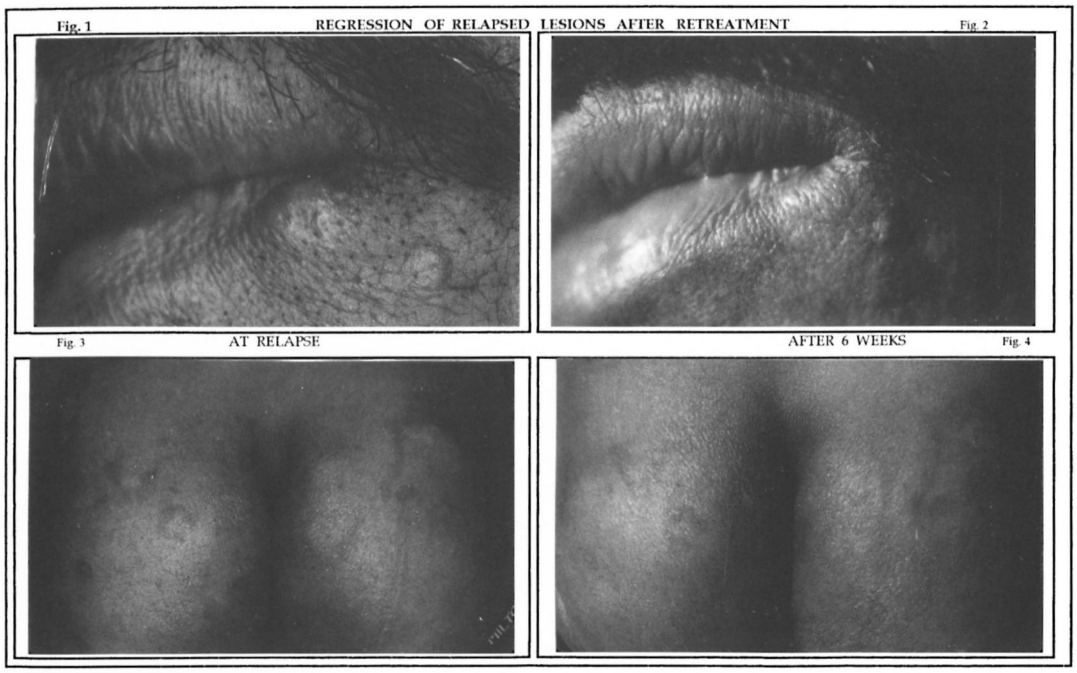
Relapse of Multibacillary Leprosy after Rifampin and Ofloxacin Treatment for 28 Days; a Case Report

To the Editor:

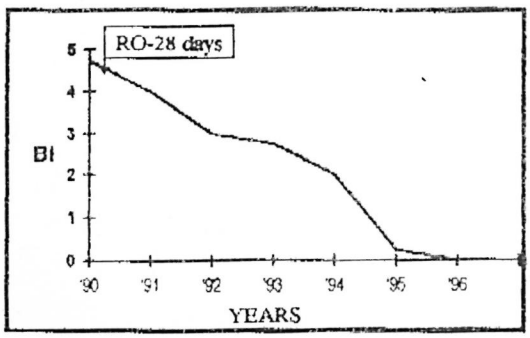
We report here on what we believe to be the first case of relapse in multibacillary (MB) leprosy following short-course chemotherapy for 28 days with daily doses of rifampin (R) 600 mg and ofloxacin (O) 400 mg.

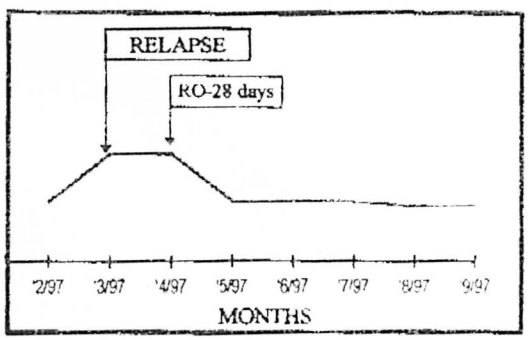
The following diagram summarizes the time sequence of events relating to a previously untreated, 30-year-old, male BL-LL patient with an initial bacterial index (BI) of



THE FIGURE. Regression of relapsed lesions after retreatment.

4.6+ who received treatment with the RO regimen from 27 December 1990 to 22 January 1991. The BI showed a gradual decline accompanied by clinical regression. The patient remained negative and sign free from 11 September 1995 ([1, 2]). Relapse of BL/LL lesions were noticed on 21 February 1997 with a mean BI of 1.3+. The case is under investigation for *Mycobacterium leprae* viability by mouse foot pad and drug sensitivity, etc.; the outcome is awaited. The patient was HIV negative.





The patient was treated with the same regimen of RO for 28 days under supervision, and the relapsed clinical lesions are regressing (Figs. 1–4). Currently, the BI is 1.3+. The satisfactory response to the same regimen so far indicates the possibility of "persisters" as the cause of relapse and not resistance to the drugs employed. The patient is under continuous observation.

All of the remaining 55 MB patients with a mean BI of >3+ included in the RO trial have reached a state of skin-smear negativity over a period of 6 years. None of them has relapsed.

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Abnormal Capillary Proliferation in the Iris of a Leprosy Patient

TO THE EDITOR:

A 63-year-old, male lepromatous leprosy patient presented with decreased vision in both eyes. He had received dapsone monotherapy for 20 years. He was clinically inactive and his skin smears were negative for acid-fast bacilli (AFB).

In 1994 the patient's right eye was operated on for cataract. At that time the right eye had a visual acuity of counting fingers, a weak orbicularis oculi muscle without demonstrable lagophthalmos, iris atrophy, a miotic pupil with posterior synechia and an intraocular pressure of 17 mmHg. During cataract extraction there was posterior capsular rupture and vitreous loss. Postoperative recovery was prolonged due to persistent uveitis requiring extended treatment with topical steroids, mydriatics and increased doses of clofazimine.

In November 1996 his right eye vision was still only counting fingers and his left eye vision had deteriorated to only perception of light. There was no acute inflammation in either eye. The left eye had had iridocyclitis in October 1994 which was treated with topical steroids and mydriatics and took a long time to resolve. There was weakness of the orbicularis oculi muscle without obvious lagophthalmos. Iris atrophy and posterior synechia were present. Since there was no acute inflammation in the left eye and no useful vision in the right eye, cataract extraction was done on the left eye. An extracapsular extraction was planned but was converted into an intracapsular extraction due to ruptured zonules. A large sector iridectomy was done and sent for histopathological examination. The vitreous face was left intact. At the close of surgery there was a large intraoperative hyphema which occupied 50% of the anterior chamber even after 5 days postoperatively. The aqueous above it developed a xanthochromic appearance. A month later the hyphema had resolved but iridocyclitis flared up in the right eye and had to be treated with topical steroids and mydriatics. An examination of the left eye done in April 1997 showed a fibrinous layer and adhesions covering the area of the sector iridectomy. The visual acuity was hand movements. The iris looked atrophic but had no rubiosis or abnormal vasculature.

The iris specimen sent for histopathological examination showed focal and diffuse infiltration of the stroma with lymphocytes, plasma cells and pigmented macrophages. The constrictor pupillae muscle was infiltrated with inflammatory cells, and there was muscle destruction. There was also an unusual proliferation of thin-walled capillaries involving the entire tissue (Fig. 1). However, in areas there were a few thick-walled hyalinized blood vessels which are normally present in the iris (Fig. 2). Some of these blood vessels showed mar-

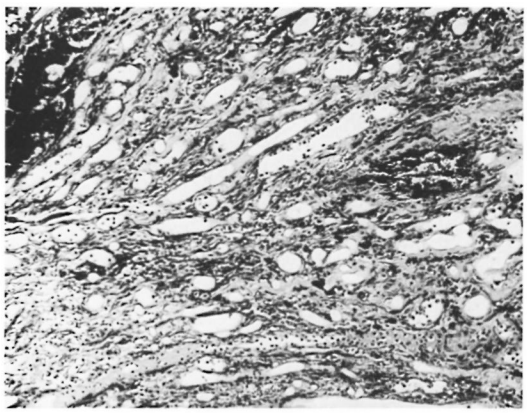

FIG. 1. Photomicrograph showing proliferating thin-walled capillaries of varying sizes lined by endothelium (H&E ×200).