Relapse of Multibacillary Leprosy After Treatment with Daily Rifampin Plus Ofloxacin for Four Weeks

TO THE EDITOR:

In a Letter to the Editor entitled "Relapse of multibacillary leprosy after rifampin and ofloxacin treatment for 28 days; a case report," published in the March 1998 issue of the INTERNATIONAL JOURNAL OF LEPROSY, Dr. R. Ganapati, *et al.* presented an excellent case report on a multibacillary patient who relapsed after treatment with daily rifampin plus ofloxacin for 28 days. However, their belief that it was the first case of relapse after treatment with the regimen was incorrect.

In collaborating with our colleagues from the Institut Marchoux, Bamako, Mali, we had observed a high relapse rate among lepromatous leprosy patients treated with the same regimen, and published the findings in the following article: Ji, B., Jamet, P., Sow, S., Perani, E. G., Traore, I. and Grosset, J. H. High relapse rate among lepromatous leprosy patients treated with rifampin plus ofloxacin daily for 4 weeks. Antimicrob. Agents Chemother. 41 (1997) 1953–1956. In fact, the abstract of this article was also published on page 81 of the same issue of IJL in which their correspondence was published.

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Dr. Ganapati, *et al.* Reply

TO THE EDITOR:

We note with concern the high rate of leprosy relapse after treatment with the promising combination of rifampin and ofloxacin (RO), as reported by Ji, *et al.* (abstract in March 1998 IJL). While recording in the same issue of the Journal our experience with a solitary case in a large sample of patients in western India, we were unaware of the documentation of similar events in Africa by a keen group of workers in late 1997 in the journal Antimicrobial Agents Chemotherapy, to which we have no access. We deeply appreciate the prompt publication by the authors and the quick abstracting by your Journal.

However, we cannot help but point out some sharp differences between the African and Indian samples studied. All of the five relapsed cases observed in the trial by Ji, *et al.* had received dapsone monotherapy before RO treatment; whereas all of our cases were untreated prior to inclusion in the trial. The significance, if any, of the possible influence of prior treatment ([1]) with dapsone is not clear and demands further scrutiny. We have earlier drawn attention to the late relapses after WHO/MDT occurring in excessively treated patients, especially with dapsone. This is in line with statements found in the literature ([2]). Another feature of the relapse after RO reported by us is the response to re-treatment with RO, indicating the possibility of "persisters" as the cause of relapse. This patient is under continuous observation for further events, if any. We also have to point out in this connection that we have already reported (under publication) on a patient who, in spite of the laboratory evidence of resistance to dapsone, rifampin and ofloxacin, has responded very well over a follow-up period of 6 years to the treatment regimen of 24 months of WHO MB-MDT, with ofloxacin daily for 28 days initially.

As regards the rates of relapse, in our sample of 98 patients after 360 patient-years of follow up, one relapse has been encountered, giving an overall relapse rate of 1.02% (95% CI 1.01%–3.05%) or 0.28 relapses (95% CI 0.28–0.84) per 100 patient-