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CORRESPONDENCE

This department is for the publication of informal communications that are of interest because they are informative and stimulating, and for the discussion of controversial matters. The mandate of this JOURNAL is to disseminate information relating to leprosy in particular and also other mycobacterial diseases. Dissident comment or interpretation on published research is of course valid, but personality attacks on individuals would seem unnecessary. Political comments, valid or not, also are unwelcome. They might result in interference with the distribution of the JOURNAL and thus interfere with its prime purpose.

Comments on Leprosy at Age 141

TO THE EDITOR:

The report of a 141-year-old man affected with leprosy (Int. J. Lepr. 1999, 67, 471–473) should draw the attention of all concerned with the disease and its victims. In their zeal to describe this exceptional case and the way it was dealt with, the authors no doubt did not realize the ethical issues they were raising.

What is the purpose of cutting pieces of skin and earlobes from a 141-year-old person, performing biopsies, or drawing blood for hematological and biochemical investigations? To confirm the diagnosis? What is the justification for treating this patient with multidrug therapy (MDT) (even the WHO-recommended schedule of MDT, thank you)? To improve his quality of life perhaps? Or to reduce the risk of infecting his contacts? Or to achieve cure after the prescribed 1-year course of therapy (he expired within 2 weeks).

Laying aside pure experimentation, was this routine management of a most unusual case the effect of some unreasoned eagerness to exterminate leprosy wherever, whenever, however, and at any cost, human or otherwise? Was it possibly the result of the blind application of some bureaucratic norms?

For centuries, often with the best intentions toward their own good or to protect the community, "lepers" were chased and isolated. They were humiliated and persecuted. They were made to suffer more from their fellow human beings than just from the disease; husbands and wives separated, children removed to die in orphan homes.

True, that was in the past. Today we know better. But do we know better? Modern technology brings with it its own perversions. In their candid report, the authors give an example of temptations that should be seriously pondered.

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Drs. Agrawal, *et al.* Reply

TO THE EDITOR:

In response to the issues raised by Dr. Michel F. Lechat, we would like to say that we have reported this case because of the patient's advanced age, and also to highlight the possibility of a long incubation period of leprosy. The skin biopsy was done to confirm the diagnosis before starting treatment in this age group. A slit-skin smear was done to ascertain the bacterial index, which is also important for treatment. Hematological and biochemical tests were done to obtain the renal and hepatic functional status which has bearing on the metabolism and excretion of drugs used to treat leprosy. Punch biopsy, slit-skin smear and venipuncture for blood samples for rou-

tine baseline investigations do not belong to modern invasive sophisticated techniques. It would have been unethical not to treat only because of the advanced age. Moreover, he was slit-smear positive and would have continued the spread of infection in the society since so many people visited him daily for his blessing. We treated definitely in the hope that he would be cured. Therefore, we are fully justified in treating this patient. The criticism regarding treating this patient with World Health Organization multidrug therapy (WHO/MDT) by Dr. Lechat raises a very pertinent question of whether elderly patients with leprosy should be treated at all and, if yes, with which MDT? In spite of knowing of his treatment he was not disowned by his family and had been well looked after. So in modern times the idea has been changed.

In the year 2000, when WHO is making an all out effort to eliminate leprosy, we firmly believe that all patients documented to have leprosy must be treated with WHO/MDT, irrespective of their ages. However, the safety of the drugs should be considered when treating any geriatric patient.

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Multidrug Therapy in Geriatric Patients

TO THE EDITOR:

While several publications are available worldwide on the efficacy and safety of the World Health Organization multidrug therapy (WHO/MDT) ([1]) program, little has been reported on the safety of MDT in geriatric patients. The case report of the 141-year-old gentleman from Nepal, who had become symptomatic for multibacillary (MB) leprosy, should now stoke an interest in the chemotherapy of leprosy in èlderly patients.

Since MDT for MB leprosy involves just once-a-month supervised therapy with clofazimine and rifampin and a daily dose of dapsone and clofazimine, the problem of patient compliance is not as great as one would otherwise imagine. Geriatric patients run the risk of adverse effects to drugs far more than younger patients. It is common knowledge that all of the drugs used commonly in the treatment of MB leprosy have side effects which are dose-related, some side effects being more tolerable than others. But where tissue perfusion is compromised due to senile and atherosclerotic changes, where drug metabolism is retarded due to changes in hepatic cytoarchitecture, where drug elimination is reduced due to senile changes in renal function, drug toxicity (due to cumulative toxicity, reduced protein binding and drug interaction) becomes much more likely and the chemotherapy of leprosy needs to be reconsidered seriously.

While it is absolutely unethical to treat leprosy patients (irrespective of their age) with monotherapy, it is equally unethical to respect their age and leave them untreated. One alternative to this conundrum could be the refampin-ofloxacin-minocycline (ROM) therapy, perhaps with a single dose. If a modified ROM therapy can be customized, keeping in mind the age of the patient, body weight and lean body mass, the safety index would be even better.

The patient in question expired after 2 weeks of antileprosy treatment. This meant that he had been administered a total of 600 mg rifampin, 1000 mg of clofazimine and 1200 mg of dapsone, much of which would have still been retained in his body at the time of his death. Just as much as his death may have been due to cardiac failure secondary to age, it might also have been precipitated by severe abdominal cramps