

THE "5 LESIONS" AND OTHER QUESTIONS

Editorial

As a guide for this classification, WHO considers as PB those cases showing 2 to 5 asymmetrically distributed lesions with definite loss of sensation; MB are those cases with more than 5 lesions, distributed more symmetrically and showing loss of sensation.

Most people don't get to separate what is an operational measure to deliver extensive treatment to a great number of individuals from the treatment of a single patient.

WHO has classified Hansen's diseased (HD) patients in paucibacillary (PB) and multibacillary (MB). PB patients include indeterminate and tuberculoid cases and MB are the borderline and lepromatous cases. This classification is to be used in the field where it is not possible to carry out neither an histopathologic examination nor a Mitsuda test and many times there is no reliable skin smears if any. In addition, in many countries the classification of the patients is made by paramedical workers.

The purpose of control measures is, of course, to cure all patients, mainly the multibacillary ones which are those that maintain the Hansen's disease endemic. Therefore, at the moment of the diagnosis it is more important to consider PB patient as a MB patient than to label a MB patient as a PB one since MB cases have a trend to a more severe evolution. Therefore, in order to avoid mistakes, in places without conditions to do any laboratory examinations, WHO has suggested simple methods to classify patients as PB and MB.

We understand that in regions where laboratories are not available these definitions should be adopt. However, in centers with reliable laboratory facilities, as in the state of São Paulo and others states in Brazil, these simple criteria give raise to many troubles.

To start with, in Brazil people in charge of diagnosis and treatment of the Hansen's diseased patients are in most part, doctors. Many of them have participated of training courses where they have learned that many cases with benign evolution, even with a trend to spontaneous resolution may present 5, 6, 7 lesions or more. They have also learned that such cases with 5 lesions or more and favorable outcome may show skin smears positive at the moment of diagnosis and that soon after the bacilli disappear without any treatment. Many of the doctors from health centers have access to histopathology and when they have a smear negative case with a histological picture showing a cellular infiltration with bacilli inside nerves endings they may have doubts to classify the case as PB or MB. On the other hand, some doctors may assimilate what is suggested from the international literature and may cause many problems mainly if they are in charge of training health personnel.

The position of WHO is very convenient to other situations. Paucibacillary cases that include indeterminate and tuberculoid ones, which frequently have a spontaneous resolution, show an excellent therapeutic result with MDT. The question is: wouldn't be very interesting to know if among the relapses observed in PB cases (1.07%) are not included the indeterminate Mitsuda negative cases which may be labeled also as a mistake in the classification?

Another convenient situation also, is that of an indeterminate patient that suddenly shows numerous red papules and plaques with or without acute neural involvement. Even considering that the only manifestations of the disease in this case are the indeterminate lesions and the reactional ones it will be labeled as a case with a type I reaction due to its good

response to steroid therapy. This patient may show bacilli in the smears or in the histology, but as this exam is not available in the field in many endemic regions, this case will be considered as suffering an immunological reaction and not a worsening of the disease. Naturally, such attitude contributes to improve the statistics of good therapeutics results.

This doesn't mean that MDT is not efficient. What causes a serious concern is that, sometimes, decisions are taken based on facts

that do not entirely correspond to the reality. It is important to have a consensus in the interpretation of some clinical facts that take place during the treatment of Hansen's disease such as type 1 reactions and others. If we passively accept proposition such as the one saying that five lesions is equal to MB Hansen's disease and that steroids can be used to distinguish reactions from relapses, we may be in risk to start to describe a new disease.

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