

SINGLE LESION LEPROSY

EDITORIAL

A new concept in leprosy has arisen about single lesions^{1,2,3} leprosy cases. There is agreement that 50% of these cases cure spontaneously and some authors believe that they even constitute a clinical entity. Based on this belief, special schedules for their treatment are being tested in several regions.

However these supposed single lesions are not always single and show immunological and evolutionary differences. If we consider only the cases with skin lesions and not those with only neurological features, we find that these lesions are hypochromic or erythematous -hypochromic macules with sensitive disorders, a plaque with alterations in sensibility, or a papule or a nodule.

When the single lesion is a macule, the case may be indeterminate, tuberculoid, dimorphous or lepromatous depending on the histopathological findings. Cochrane⁴ called attention to some of these lesions which he called pre-dimorphous and pre-lepromatous lesions but he stated that they were always multiple and symmetric and never mentioned that they could also have a stage as a single lesion.

As to the indeterminate and tuberculoid macules, in the Congress of the Cairo⁵ in 1938, they were included in the Neural type, as simple macular lesions, alongside the minor and major tuberculoid and the neuro-anesthetic lesions. Later, in 1945, in the Havana Congress⁶, the sulamerican authors introduced the term "uncharacteristic" to label these macular lesions with unspecific histopathological infiltrations in order to distinguish them from macular lesions with tuberculoid infiltrations. Indian leprologists considered these macules as a separate group and designated them as maculo-anesthetic lesions. In the Congress of Madrid⁷ in 1953, the term "uncharacteristic" was substituted by the term "indeterminate" and after many discussions the maculo-anesthetic form recognized by the

indian researchers was incorporated into the tuberculoid classification with the designation of macular tuberculoid.

Indeterminate macules may be single or multiple. Cochrane⁴ admitted as indeterminate cases those with two to four macules. The lesions of indeterminate cases that can present a positive or negative Mitsuda's reaction, have faint edges, negative bacilloscopy, and an unspecific infiltration of the dermis where only very few bacilli could be found inside nerve twigs. The Mitsuda-positive cases could be self-curing without treatment or could evolve to the tuberculoid type. The Mitsuda-negative cases evolve to borderline or lepromatous forms.

Therefore cases with single lesions are more complex than they seem at first.

It seems that Southeast Asian countries may have a high proportion of Mitsuda positive cases with single macules of the indeterminate group, single macules and plaques of the tuberculoid type and single papules or nodules which we in Brasil know as childhood nodular tuberculoid leprosy^{8,9,10,11,12,13}. However in South America, Mitsuda-negative indeterminate lesions are more frequent as are cases with borderline and lepromatous leprosy.

It was because of this situation that the Brazil resisted for some time the implementation of the MDT/WHO with duration of 6 month for the paucibacillary cases¹⁴ because in its definition of paucibacillary, Brazil did not include the Mitsuda-negative indeterminate cases¹⁵. However, after seeing the results of nine years of follow up of PB cases treated with MDT/WHO in all the world which showed a relapse rate only of 1,07%¹⁶, Brazil reconsidered its decision and began to include in its definition of PB cases, the Mitsuda-negative indeterminate cases¹⁷. In spite of this we must to remember that the mean time for a indeterminate of leprosy to evolve to a polar type

is five years- less for tuberculoid type and more for the lepromatous type⁸. Therefore, Brazil, which adopted the fixed dose regimen for all indeterminate cases only in 1994, should wait a few years more in order to have its own data on the relapse rate of Mitsuda-negative indeterminate cases treated with MDT/WHO.

Be that as it may single lesions cases should not to be considered a separate clinical entity and we not view with too much optimism the possibility of spontaneous regression. These lesions are part of various clinical forms and they may suddenly to evolve to a reactional tuberculoid or borderline forms or slowly evolve to a

lepromatous form.

In spite of the fact that 1200 mg of rifampicin destroys 99,99% of bacilli and would be more than sufficient to destroy the few bacilli in PB cases¹⁸. WHO recommends a dosage of 3.600 mg for these cases. Single-dose combined regimens with highly bactericidal drugs^{19,20,21,22} that we have access to now probably will be effective in these single lesion cases. But we caution that cases in which these drugs are used should be followed for considerable time in order to have reliable information as to results.

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