Declaration of patient consent
Patient consent is not required as there are no patients in this study.

Financial support and sponsorship
Nil.

Conflict of interest
There is no conflict of interest.

Use of Artificial Intelligence (AI)-Assisted Technology for manuscript preparation
The authors confirm that there was no use of Artificial Intelligence (AI)-Assisted Technology for assisting in the writing or editing of the manuscript, and no images were manipulated using the AI.

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Authors' reply

Sir,

This is with reference to the letter to the Editor published as 'Redesigning multi-drug therapy: Hasty or judicious?'[1] based on our article 'Efficacy of fixed duration multidrug therapy for the treatment of multibacillary leprosy: A prospective observational study from Northern India'.[2] We would like to thank our readers for taking an interest in our article. The valuable readers have commented regarding the antimicrobial resistance (AMR) testing for all the viable bacilli positive cases after completion of the treatment and if the second-line treatment was taken into consideration or not. In our study, all the cases were tested for the presence of viable load of bacilli after the completion of therapy. However, AMR was done at the time of recruitment only. If the patient was found resistant to any of the drugs of MDT, the regimen was shifted to alternate regimen as recommended by the WHO. We have already published one comparative study on the resistant cases with both MDT vs. WHO-recommended alternate regimen. We tested the load of bacilli in 175 new cases before and after the therapies. In our previous study, we administered a group of rifampicin-resistant relapse cases with an ALT regimen and compared their BI with another rifampicin-resistant group administered the WHO-MB-MDT regimen. We observed in this study that there was a significant reduction in the BI during the treatment of rifampicin-resistant cases with the ALT regimen ($P = 0.0009$). We showed that alternate regimen is showing good response in bacillary clearance in comparison to MDT.[2] The readers have also commented on the accuracy of the reporting of acid-fast bacilli in H&E image. No AFB was appreciable in Figure 1 as AFB visualisation mostly requires special staining procedure (Ziehl Neelsen staining & Wade Fite staining), so the assertion of showing isolated acid-fast bacilli in H&E stain is not correct. In our study,[1] we have done H&E staining to find out whether the granuloma is still active after 12 months of treatment. Hence, the figure legend to Figure 1 mentioning 'Arrows showing foamy macrophages with acid fast bacilli and active granuloma in panel B' is wrong. This error is inadvertent and we sincerely appreciate the readers' feedback on this. We agree that the legend should now read as 'Arrows showing foamy macrophages and active granuloma'.

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