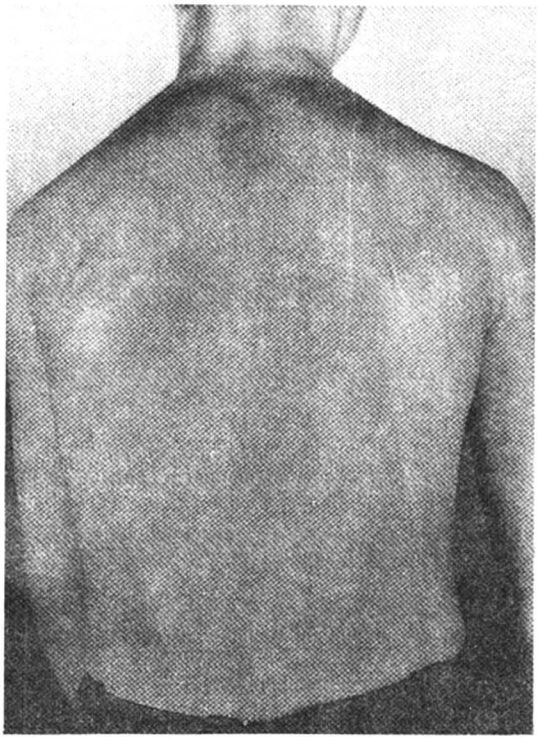

Fig. 2. Hypopigmented macules on the back resembling "christmas tree" pattern.

of nerve involvement. A diagnosis of pityriasis rosea was made at this juncture.

However, there was history of a prolonged continuous fever for 5 months with swelling in the left side of abdomen about 4 years before the onset of skin lesions. This was successfully treated with about 20 intramuscular injections of pentavalent antimony after being diagnosed as kala-azar. The patient belonged to Ramnagar (UP) which is an endemic area for kala-azar.

The histopathological examination of the biopsy specimen taken from a lesion showed in the upper dermis an infiltrate of lymphocytes, plasma cells and histiocytes. The slit-skin smear examination was inconsequential. The diagnosis was changed to post-kala-azar dermal leishmaniasis (PKDL). This case is being reported because of its peculiar resemblance to the post-inflammatory changes of pityriasis rosea.

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FIXED DURATION MDT IN LEPROSY

To the Editor,

This letter is in reference to the article by Paramjit Kaur and Gurmohan Singh on 'Fixed duration MDT in leprosy and clinical cure' (IJDVL 1996;62:33-5).

We think practically all will agree that it is advisable to achieve clinical cure. We however do not agree that the patients covered by the national programme should have different treatment than patients under care of dermatologists. This is especially so because of the ever increasing incidence of relapses after FDT.[1]

We are giving herewith the opinion of practising dermatologists from all over Maharashtra (except Mumbai) who were asked questions related to FDT. Out of the 142 dermatologists contacted 92 responded.

1. For monolesional paucibacillary cases 88.1% do not stop treatment at the end of 6 months as suggested by WHO.

2. For paucibacillary cases with multiple lesions 81.5% do not stop treatment at the end of 12 months as suggested by WHO.

3. For multibacillary cases 93.5% do not stop treatment at the end of 24 months.

Thus overwhelming number of dermatologists give importance to the clinical activity and do not follow the FDT schedules as suggested by WHO.

We would like to add from our experience that with relative affluence in our state, not so costly MDT and availability of qualified dermatologists in all district places

and most of the taluka places, dermatologists are treating more leprosy patients in their clinics than the patients being treated at the government hospitals.

One of us has tried to give a critique of the WHO schedules and suggested that the urgency of reducing the duration of therapy is unnecessary and may prove counterproductive in the long run.[2]

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2. Kulkarni V. Will extensive use of WHO recommended MDT regimens control leprosy? some reflections. ILA Forum 1995; 2: 8-13.