Dr. Freerksen's Reply to Dr. Vellut

The article on H.D. by Professor Enno Freerksen, Professor Emeritus and former Director of the Research Institute, Borstel, West Germany (NJI: January, 1983) attracted a critique of some of the remedies advocated in the article from Dr. C. Vellut, Secretary, India, Damien Foundation (NJI:March, 1983) a devoted fighter against leprosy who was awarded a Padma Shri by the President of India. Here below is the reply of Dr. Freerksen to Dr. Vellut's critique.

I THANK Dr. C. Vellut for her critical reaction (NJI:March 1983) to my therapy suggestions. It gives me an opportunity to comment on some typical and obviously wide-spread misconcepts:

1. Trials with the form of therapy suggested by me are under way at several places of the world. The Malta Project was started in 1972 already and has been thoroughly and continually checked for 10 years. There is no doubt that the therapy used is the most effective and best tolerated which is available today. This claim was verified and confirmed by a consultant of the WHO (Dr. Leiker).

2. In 1980 a larger, joint tuberculosis/leprosy eradication programme was launched in Paraguay. It is proceeding in the same smooth and successful way as the Malta Programme.

3. In the future only fixed combinations will be used, especially in the so-called underdeveloped countries. This is the only way to ensure correct and simple drug intake. Our experience of the last 15 years indicates that the correct intake of combinations in form of single drugs is impossible particularly when they are self-administered. The use of fixed combinations has also been advocated by Dr. Levy, WHO.

4. As all effective drugs, Protionamide and Rifampicin exhibit a certain toxicity which is, however, lower than that of DDS. Our experience indicates that their toxicity is no serious drawback for therapy and does not require a more severe control of the patients than with DDS therapy.

Meanwhile, many hundred thousands of patients all over the world have been treated with Rifampicin. I myself have rarely seen reactions requiring the discontinuation of therapy. Complications are seldom observed, and do not only occur under RMP administration.

5. In the treatment of leprosy RMP should always be included in combinations exhibiting simultaneously a strong antituberculous effect. It is very likely that leprosy patients suffer also from tuberculosis or from a tuberculous infection. This fact may be known or not —it is at any rate advisable to use forms of therapy resulting in the cure of both diseases. A basic therapy with DDS, supplemented by a single dose of RMP and lamprene once a month, does not meet these demands. It does not prevent the emergence of DDS resistance, and the leprosy bacteria may even become resistant to RMP. Besides, it will result in resisance of M. tuberculosis to RMP. Intermittent doses of RMP may also activate latent infections, thus rendering our best weapon in the treatment of tuberculosis ineffective. For this reason alone such forms of therapy are dangerous. Every physician who is familiar with mycobacterioses (including leprosy and tuberculosis) can only deeply regret such therapy recommendations.

6. It has been repeatedly claimed that INH is ineffective in the mouse footpad test. This claim is based on results obtained with INH monotherapy. This method is completely useless for testing combinations. Quite apart from this, the ineffectiveness of INH alone in the mouse footpad is of no importance. Extensive studies have shown that INH is indispensable in the combination we suggest for the treatment of leprosy. With regard to results obtained in the mouse footpad test—as with animal tests in general—it must be considered whether or not they may be of importance for human therapy. The unconditional belief in the indicative value of the mouse footpad test with regard to the suitability of a form of therapy for human leprosy is a puzzle to everyone performing animal tests.

7. The situation on Malta is special inasfar as our project could be carried out under good conditions. The possibilities of control and examination that existed were better than generally encountered in leprosy-affected countries. This supplies further evidence for the effectiveness of the Malta Project. It was the first project including a very long, thoroughly performed relapse control period. This is of utmost importance. A therapy which does not prevent relapses is of little use. So far no relapse occurred on Malta.

8. It is absurd to claim that the scientific background of the Malta Project has not been clearly defined. There is no other form of therapy which has been so thoroughly tested in chemical, microbiological, experimental and clinical studies prior to the decision to conduct a project as that on Malta. Our preliminary studies have been described in detail in our publications. Our arguments have been accepted by the experts; there remain some desk experts who do not recognise their validity.

9. I regret very much that Dr. Vellut advocates the treatment of multibacillary cases with single doses of RMP and lamprene once a month and the daily intake of DDS. The experience gained so far with this therapy

is unsatisfactory, and its scientific background is unclear. Besides other critical points it must be realized that it is, in principle, DDS monotherapy not sufficiently supplemented by other drugs. It will certainly lead to DDS resistance, but not prevent it.

10. Theoretically, the suggestion to administer RMP continuously for 3 weeks is better, but does not correspond to practical experience. It is more reliable to give 600 mg of RMP daily together with INH, PTH and DDS for a total of 8 weeks. This is the minimum initial treatment time for every leprosy patient. Therapy is then continued according to the requirements of each individual patient.

11. There is no reason for making a difference between multibacillary and paucibacillary cases. They cannot be recognized by skin symptoms. Large numbers of bacteria may be present in the liver or in the bone marrow, but not in the skin. Chemotherapy must be directed against all bacteria in the patient's body, not only against those in the skin. Therefore, no differences should be made with regard to the composition or dosage of the medication, but only with regard to treatment duration.

It has repeatedly been claimed, but never proven, that lamprene has not only an antibacterial but also an immunosuppressive effect. Even if this claim were true, the reasoning is wrong. The best immunosuppressive effect is obtained by using a highly active antibacterial therapy, as it reduces the amount of antigens. It has been observed that reactions rapidly subside and disappear completely in patients receiving a well-conducted chemotherapeutic treatment. Additional immunosuppressive measures will soon become superfluous when an effective chemotherapy is given. When initially required, thalidomid should be administered, or cortison.

13. Each therapy must be continued until clinical improvement and bacteriological negativity have clearly been obtained in the patient. Two years of treatment are too long for many patients, and too short for others. It is, therefore, dangerous to postulate a uniform treatment duration for all patients.

14. It is easy to think out, at the desk, any theoretical objections to each form of therapy. But only the results gained in practice are decisive for the success of a therapy not directed at gaining prestige, but at helping the patient to get rid of his disease. All other aspects might be of interest, but they are of no importance in practice. In leprosy research it would be of advantage if less new, more or less founded therapy recommendations were made, and force and money used instead to help the world to overcome the leprosy problem. It was announced by the WHO that 'Health for All' should be achieved by the year 2000. It is of no use to discuss whether this aim can be realized everywhere. There is no doubt, however, that it can be reached with regard to leprosy (and tuberculosis). This would require, however, less words and more deeds.

Attention, Members Bihar State Branch !

The General Body Meeting of the TNAI Bihar State Branch would be held at Duncan Memorial Hospital, Raxaul from April 28 to 30, 1983. The tentative programme of the meeting is given below:

28.4.83

8 a.m.-12 noon	Registration of delegates
10 a.m.	Executive Committee meeting
3 p.m.-6 p.m.	Inauguration Special Speech of Chief Guest Election of S.N.A. Office Bearers
7.30 p.m. onwards	Variety Programme

29.4.83

9 a.m.-1 p.m.	Election of Office bearers for TNAI Professional Sharings Business sessions
3 p.m.-4 p.m.	Special talk
4 p.m.	Sight seeing

30.4.83

Picnic to Nepal

The information about your arrival, period of stay, accommodation, food, etc. be sent to the Nursing Superintendent, Duncan Memorial Hospital, Raxaul.

Mrs. Chandrakala Singh,
Secretary, TNAI Bihar Br.