time to remission, the duration of remission with treatment and the relapse-free period after stopping therapy: outcomes of importance to patients and dermatologists alike. I would like to make a comment on the utility of immunofluorescence testing in determining the length of treatment. There are few situations where indirect immunofluorescence (IIF) testing is of any significant diagnostic value in pemphigus. Its role in predicting prognosis is also limited. Direct immunofluorescence (DIF) testing fares better in predicting relapse-free remissions but is not reliable enough to be useful in everyday clinical practice.\(^1\) ELISA for antibodies to desmoglein 3 and desmoglein 1 is a relatively new test and time will tell if it will have much application in prognosis though this appears unlikely from previous experience with IIF. For the present, it appears that we will have to continue our search for reliable predictors of the response to treatment.

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REFERENCES

Response by Dr. Pasricha

Sir,
This is to thank Dr. Navin Modi and Dr. Gandhi et al for their comments/suggestions on the articles on pulse therapy in pemphigus published in the IJDVL.\(^1\)\(^2\)\(^3\)\(^4\)

My response to the comments is as follows:

1. The duration of infusion of dexamethasone between 1 to 2 hours has been found to be safe. In case the infusion is more rapid it can produce some disturbances in the heart rate, while if it is too slow it may not produce the peak levels as produced by the 2-hour infusion. The same is true of the oral pulse.

2. Use of azathioprine or methotrexate at Hyderabad is a welcome modification\(^2\) and deserves to be assessed further.

3. The suggestion to use cyclophosphamide pulses instead of daily cyclophosphamide\(^4\) needs to be evaluated to see if it will produce equal or better results. I feel the patients would prefer to swallow a tablet daily rather than have a drip. Cyclophosphamide toxicity among our patients is already negligible because our patients drink a lot of water. In an occasional patient who develops toxicity, MESNA and other measures may be used. I am not in favor of using too many drugs as a routine in every patient.

4. Should one depend upon the results of direct immunofluorescence (DIF) and indirect immunofluorescence (IIF) to decide the duration of phase II and phase III? This needs to be assessed. Most of our patients show negative or low titers at the end of phase III, but I have also found positive DIF/IIF even 5 years post-treatment even when there had been no clinical relapse. I find it very difficult to assess which patient requires more treatment and which one requires less. Neither the percentage of body area of involvement at the start of the treatment nor the IIF titer seem to have any bearing on the promptness of the recovery in each case.

5. Shortening the duration of phase II and phase III seems to lead to a higher rate of relapse as also the administration of the pulses at irregular intervals rather than the exact 28 day cycles.

6. I feel the use of immunoablative high dose of cyclophosphamide is more risky and would not like to use it.

In conclusion, every worker has a right to modify the original regimen and any regimen which produces
better results in the form of a quicker recovery, a lower relapse rate, fewer side effects or a shorter duration of treatment is welcome. The patient should be the ultimate beneficiary.

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REFERENCES

Rheumatological manifestations of leprosy

Sir,
I read with interest the recent article by Vengadakrishnan et al. They have reported a high occurrence of arthritis in patients with leprosy. However, I would like to make certain observations.

Leprous neuritis leads to a damage of the sensory nerves supplying joints. Therefore, neuropathic (Charcot's) arthropathy involving the weight-bearing joints, such as those of the feet, occurs in more than 10% of patients with leprosy. Involvement of non-weight bearing joints, such as the wrist, has also been reported. Patients may fail to note the development of neuropathic arthropathy due to the absence of pain. This fact was highlighted by a study which found that MRI studies detected significant changes in the feet in all asymptomatic patients with leprosy. Vengadakrishnan et al have not presented data on this aspect in their study.

Another point worth noting while studying the association of leprosy and rheumatoid arthritis (RA) is the efficacy of dapsone in ameliorating the symptoms of RA as effectively as chloroquine and hydroxychloroquine. The mode of its anti-inflammatory action in RA is not clearly understood, but modulation of neutrophil activity or inhibition of neutrophil inflammatory product formation or release appear to play a role.

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REFERENCES