uloma [9] with invasion of dermal nerves and axonal damage [10]). Thus, all of the features of maculo-anesthetic leprosy have been reproduced in this experimental model. In contrast, injection of viable M. lepraem into animals has failed to reproduce any of the features of this form of the disease.

The image on the cover of the 1 November 2009 issue of the journal, which depicts a leper with a bell, is misleading [11]. It is not based on a named individual. It shows severe mutilation in the presence of florid leprosy lesions, which, according to Hansen [3], cannot occur. It is also incorrect in showing that the mutilation—and therefore the underlying sensory loss—is asymmetrical, whereas the sensory loss is in a glove-and-stocking distribution [12, 13].

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References


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Reply to Crawford

To the Editor—As the cover art editors for Clinical Infectious Diseases, we were interested to read Dr. Crawford’s letter, in which he presents an interesting case for what may be a medical incongruity with manifestations of both multibacillary and lepromatous leprosy present in the same person, if the 2 forms of the disease (defined using 2 different classification systems) are indeed mutually independent and represent separate, invariant, pathologic pathways with nonoverlapping clinical signs [1]. Whether such is the case is not germane to the illustrations, however. Although it is certainly possible that the visible manifestations of leprosy may have evolved over the 600–700 years since the paintings were made, the salient fact is that artists throughout time have taken “artistic license” in depicting persons and scenes in their works, whether it be in the form of exaggeration, minimization, chronologically impossible groupings of historical figures, or distortion of perspective to emphasize relative importance. Combining the most distinctive features of a disease (as appreciated in the twenty-first century) in a single individual, whether medically accurate or not, would have been neither surprising nor misleading to the public or the “medical community” of the fourteenth or fifteenth centuries.

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Reference


Hepatitis E Virus and Person-to-Person Transmission

To the Editor—I have read with interest a paper by Teshale et al [1] in a recent issue of the journal. The authors report their findings during a large outbreak of hepatitis E virus infection in northern Uganda and indicate that these findings provide evidence supporting person-to-person transmission of this infection, which has previously been believed to be infrequent [2, 3]. In their study [1], the primary arguments in support of person-to-person transmission of hepatitis E virus are that (1) the secondary attack rate of hepatitis E virus infection within households was high, (2) persons residing in households with multiple cases of hepatitis E virus infection and persons residing in households with a single case or no cases of hepatitis E virus infection had differences in certain exposure or behavioral characteristics, and (3) no continuing source of infection (eg, a source of contaminated water) was found. However, some of these findings may have alternative explanations other than person-to-person transmission.

The secondary attack rate of an infection within households, interpreted as the proportion of other members in a household with infection after the occurrence of an index case in that household, depends heavily on the overall disease rate

CORRESPONDENCE • CID 2010:51 (15 August) • 477