INTRODUCTION
Leprosy is one of the most challenging diseases known today, ranking cancer in its damage and lack of adequate knowledge but even more challenging because of what leprosy does to its victims physically, socio-economically and psychologically.

It is a disease of great antiquity. The leper has for centuries been a social outcast, partly, from biblical times he was regarded as unclean and partly because his repulsive appearance and disabilities prevented him from being an acceptable member of the community.

Hatred and ostracism cause concealment of the disease on the part of patients until it becomes too obvious. In doing so, the sufferer unintentionally helps to exaggerate the disease in himself as he remains without any treatment. Consequently, disease takes longer time in becoming acute enough to manifest itself too obviously in the patient. Even by this time he would have infected many other persons in his community.

The total number of leprosy cases in the world are estimated to be approximately 12 million. This figure for India being about 3.8 million patients and it is widely distributed in all parts
of this country. Causative organism of this disease is Mycobacterium leprae bacilli which was recognised by Hansen in 1874.

Clinically leprosy is manifested in two main clinical forms, lepromatous leprosy and tuberculoid leprosy and these two types represent the opposite poles - lack of resistance and resistance in host, respectively. Thus realising the importance of host immune status, an immunological approach may help in proper pathogenesis, diagnosis, control and prevention of leprosy. Ridley and others (1966) have provided nomenclature, in the form of a system of diagnostic classification that is fundamental to most current immunological investigations.

As an elaboration of polar concept, Ridley and Jopling (1966) first proposed a system of five numbered classification. They retained the traditional tuberculoid pole (TT), lepromatous pole (LL) and borderline (BB) group, but added two intermediary categories, borderline with tuberculoid features (BT) and borderline with lepromatous features (BL) - TT, BT, BB, BL, LL, comprise a spectrum in continuity. They also explained that each stage in spectrum was determined by the result of host response to antigens of Mycobacterium leprae. Patients with BL have more immunity against Mycobacterium leprae than do the LL but less
than patients with HP and TF. So it indicates that TF patients have highest and LL have lowest immunity.

Landsteiner and Chase (1949) demonstrated that delayed type of hypersensitivity could be conferred on non-reactive subjects by transferring living lymphoid cells from sensitized donors. These observations provided the foundation for science of cellular immunology. The past few years have shown that T cell count, PHA response, response to chemicals such as DNCB and graft transplantation, may help in assessing the cellular immunity.

Present study has been undertaken to assess the cellular immunity in different types of leprosy patients. The tests, which were taken in assessment, were status of T-cell and B-cell in peripheral blood, lymphocyte response to PHA and skin recall test using lepromin and candida antigens.

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